PUBLIC HEALTH NURSING

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CONTENTS

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Public Health Nursing

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NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING; and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members and its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity and the acceptance of any of its recommendations is entirely voluntary.

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ONE OF the treasured privileges of a citizen in a democracy is his right to vote. Thus can he guide his own destiny. If he is a professional person such as a public health nurse by his vote he also helps to shape the future of the nation because public health nursing serves the nation.

The Nominating Committee of NOPHN can be proud of a job well done in the ballot for officers, directors, and nominating committee for the next biennial, presented on page 362. While members will receive in August an official notice of the biennial election with the proper forms for voting by mail, publication of this list of names in advance with detailed information about each candidate gives NOPHN voters a chance to study the slate and to consider some of the fundamental principles involved in the final selection of the men and women who are to represent them in the direction of the National Organization program during the next two years.

Each one on the list has expressed his willingness to serve if elected. The thanks of the members are due all of them for their interest and cooperation. All of them know that this is a "working" job, one which will entail considerable self-sacrifice in the sense of undertaking of responsibility and expenditure of time. We should take pride that this distinguished group of people is ready and willing to make so great a personal contribution to NOPHN if called upon.

Then, too, there is something very different about this slate of officers. For the first time since 1930, two candidates are offered for the offices of president, first vice-president, and second vice-president. This has been done in accordance with the widespread conviction expressed by members that "where there is no choice, there is no vote."

Several general considerations guided the Nominating Committee in their selection of names. The Board of a national organization should represent all parts of the country. It should reflect the interests of official public health nursing services as well as voluntary visiting nurse associations. It should represent the consumers of nursing service as well as the profession which gives it. Organized labor is playing an increasingly constructive role in the development of adequate health programs and facilities for working people. They have much to offer us in national planning. Negro nurses want and have a right to participate in plans which affect them as all nurses. They have made an inspiring contribution to scientific thought and progress in this country and we should all have the opportunity to profit from what they are willing and able to give us in our national program.

One way *not* to vote is to run hastily through the names and check those we've heard of before! Study the "Who's Who." Get to know these people. They deserve your time and attention.

Health Legislation

AS OF LATE June not much progress had been made by Congress in regard to some dozen important health bills under consideration. [See PUBLIC HEALTH NURSING, April 1946, p. 149.]

Passage by both Senate and House of the National Mental Health Act, which is now awaiting the President's signature, is the most important accomplishment to date. One vital point of the Act concerns the need for training personnel in the mental health field. A program is contemplated under the bill which

would probably require the services of a large number of well qualified public health nurses.

The bill to continue the social protection program in the Office of Community Services, Federal Security Agency, has been passed by the Senate and sent to the floor of the House. Early action is expected.

The National School Lunch Act is now law.

Other bills, the Maternal and Child Welfare Act of 1945 (Pepper Bill), the Hospital Survey and Construction Act, various dental health bills, National Health Act (Wagner-Murray-Dingell Bill), the General Housing Bill, Minimum Wage and Child Labor, are still held up in House or Senate Committees.

Hearings on the Maternal and Child Welfare Act of 1945 (HR4059) began late in May before the House Subcommittee on Aid to Physically Handicapped. Ruth Houlton, general director of the National Organization for Public Health Nursing, appeared before the Subcommittee on June 6 with a statement setting forth the concern of public health nurses for the improvement and expansion of preventive and curative health services for the entire population but particularly for mothers and children, and the need for a large increase in public health nurses qualified and prepared to carry on the functions required of them in an expanded health program. Her statement follows:

The National Organization for Public Health Nursing is a membership agency comprising 9,268 public health nurses, 356 public health nursing agencies, 973 non-nurse citizens, and 22 state branches. It acts as a medium through which public health nurses and other interested citizens express opinions and provide information on public health nursing as assembled from their collective experience.

Public health nurses have actively manifested their concern for the improvement and expansion of preventive and curative health services for the entire population. This interest was formalized by resolutions passed at the Biennial Convention of the NOPHN in 1944 which state that:

1. Means should be found to bring medical and public health services within the reach of every citizen.

2. In addition to voluntary effort, governmental assistance is necessary for attaining adequate provision of health services.

3. To carry on public health nursing functions in connection with expanded programs of public health and medical care 40,000 additional public health nurses will be needed.

4. Pressing need of public health nursing personnel requires added facilities for recruitment, training, and postgraduate education.

The NOPHN, while it does not lobby for specific legislation, is much concerned with all programs affecting the health and welfare of our population. That public health nurses are alert to the needs of mothers and children is evidenced by the proportionate amount of nursing activities devoted to their care. Data collected by the NOPHN from a representative sample of agencies show that in nonofficial agencies 13.6 percent of all public health nursing visits were made to maternity cases, 20.1 percent to infants and preschool children, and 0.3 percent to the school-age child. In the official agencies 8.6 percent of total nursing visits were made to maternity cases, 29.9 percent to infants and preschool children, and 11 percent to the school-age child. Approximately one third of all home visits made by public health nurses are to mothers and children.

We would call your attention to Exhibits I and II [two maps were attached] which show a comparison of the United States Census Maternal and Infant Mortality rates with a distribution of public health nurses. They reveal that in the areas where the need is the greatest the amount of nursing service is lowest. This in itself suggests the need for more public health nurses.

Foremost authorities in the public health field have accepted a ratio of one public health nurse to 2,000 population as meeting the basic needs of a community including care of the sick in the home. As of today two states only—New Hampshire and Connecticut—approximate this standard. More than 65.7 percent of our cities, with a population of 10,000 to 25,000, have no organized community resources for public health nursing care of the sick in the home. Approximately one third of all the counties have no public health nurses giving maternity and child health services.

To provide basic service to every county in the 48 states will necessitate an increase of approximately 40,000 well qualified public health nurses. To prepare these nurses and to better equip those already in the field, additional training facilities, instructors, and field supervisors are essential. Perhaps the best

(Continued on page 338)

Modernizing Practices in Maternity Hospitals and Newborn Baby Services

By MARGARET LOSTY, R.N., LEONA BAUMGARTNER, M.D., HAROLD ABRAMSON, M.D., AND SAMUEL FRANT, M.D.

ONE OF THE MOST encouraging signs with respect to health in the United States is the continuing decline in infant and maternal mortality rates. In the ten years from 1934 to 1944 the infant mortality rate fell 31 percent and the maternal rate 60 percent. There are certainly many factors at work making for this decline; factors such as the greater use of hospital facilities, the use of penicillin and the sulfonamide drugs, the wider use of blood and blood substitutes in controlling hemorrhage and shock, and the efforts of medical, hospital, and public health authorities to raise the standards of medical and nursing practices and of hospital care. But despite these gains much remains to be done. The majority of newborn infant deaths are attributed to various causes associated with childbirth such as congenital malformations, birth injuries, and prematurity. Deaths from these causes have not decreased as rapidly as have those from other causes. This does not mean, however, that many newborn infant deaths cannot be prevented. The Children's Bureau,[1] for example, estimates that a further 50 percent decrease is possible with the knowledge we are accumulating.

Analysis of the problem indicates there is one line of attack which can be pursued more actively, that toward the reduction of preventable deaths in maternity hospitals. Deaths in the first week of life accounted for 50 percent of the 118,000 infant deaths in the United States in 1943. Many of these were in hospitals and were preventable. Diarrhea and enteritis alone killed 10,000. Small wonder then that more and more attention is being focused on this problem of neonatal mortality in maternity hospitals. The Maternal and Child Health Section of the American Public Health Association held a symposium on this problem at its last annual meeting.[2] Departments of health in cooperation with various obstetrical and pediatric societies have studied intensively the problem related to the well recognized clinical entity, epidemic diarrhea of the newborn, a frequently fatal diarrheal disorder affecting newborn infants.[3] Some health departments have added personnel to their staff to cope with the problem.[2]

Responsibility for the licensing and inspection of hospitals has frequently been delegated to health departments. Too often, however, these activities are chiefly concerned with the rudiments of sanitary control and follow-up investigations in outbreaks of infectious disease. Clearly this is not enough. And so an expanded type of service has been developed to include supervision of nursing technics, epidemiological studies, and consulting pediatric and obstetrical services. The Emergency Maternity and Infant Care program has also increased the activities of health departments in inspecting maternity hospitals. There has been a tendency to develop all these services along educational lines, recognizing that it is only as all personnel in nurseries come to realize what good practice is, that real progress can be made. Because this type of service is new in health departments, it seems wise to record the recent experiences of the New York City Department of Health in improving standards of maternal and new-

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born infant care in lying-in hospitals in the city.*

HOSPITAL SURVEYS

Department sanitarians and epidemiologists had long visited hospitals when problems arose. Particular attention had been given to the control of outbreaks of diarrhea in hospitals since 1934, when the syndrome called "epidemic diarrhea of the newborn" was first described.[4] Standards for maternity hospitals had been set up in a section of the Sanitary Code in 1937.[5] Conditions seemed to be improving. Infant mortality rates were falling steadily and had reached an all-time low of 28.8 per 1,000 live births in 1942 for the city. But during the summer and fall of 1944 an increase in infant deaths occurred together with an increased number of outbreaks of epidemic diarrhea of the newborn in hospitals.

Clearly this was a hospital problem. Concurrently the birth rate was rising and there was a tremendous demand for maternity services. Hospitals faced shortages in personnel and equipment.

STEPS TAKEN

The Department of Health realized that some additional measures were required. With the limited nursing personnel available it seemed clear that the best hope lay in getting hospital staffs themselves to review all technics as to safety, simplicity and necessity. Only the simplest and safest nursing procedures could be used and many luxury services had to be abandoned. To help hospitals streamline their nursing services, the Department of Health assigned a public health nursing supervisor to this specialized work. For a six-week period a public health nursing consultant who was experienced in making hospital inspections in a neighboring state department of health assisted in initiating the new program. Subsequently, two other nursing consultants were assigned to this work.

The first objectives were the accumulation of additional facts through surveys of actual conditions in hospitals by the Department of Health staff and consultation with other community leaders and community groups. Then the following additional steps were taken:

1. Formulation in cooperation with heads of obstetrical, pediatric, and maternity nursing services of *Standards and Recommendations for Maternity Hospitals* to supplement the existing Sanitary Code governing the conduct of lying-in hospitals. Suggestions for simplification of nursing technics were included. Personnel practices and adequate equipment were discussed. Approved by the Department of Health and by professional leaders outside the Department, such recommendations were of more value than mere directives or suggestions by any one group. Approval of these recommendations was also secured from various organized professional groups. The nursing technics recommended were chiefly those by which each infant's and mother's care could be individualized, particular attention being paid to eliminating the chance of cross infection. In general, they followed those procedures previously described.[2]

2. An organized educational campaign was then begun. With the cooperation and support of the New York City League of Nursing Education and the district groups of the New York State Nurses' Association, meetings were devoted to the problems of reducing newborn infant mortality in maternity hospitals. Mortality figures were presented, the results of the first hospital surveys explained, and means of using personnel to the best advantage with simplification of technics suggested. Copies of the *Standards and Recommendations for Maternity Hospitals* and other appropriate literature were distributed. Free discussion of problems was encouraged. Meetings with other interested groups followed.

BASIC PROCEDURES

As hospital surveys continued, the need for a pediatrician and an obstetrician in the program was soon evident. The nursing consultant usually "went early and stayed late" and made pertinent observations. But in order to make an effective survey and to secure the active cooperation of the hospital, a physician from the Department of Health accompanied the public health nursing consultant. Often the nursing staff in the hospital could not act unless the hospital medical staff agreed to certain changes. At times, the hospital administrator and medical staff were

*The New York City Department of Health does not license hospitals, but works closely with other public agencies concerned with standards.

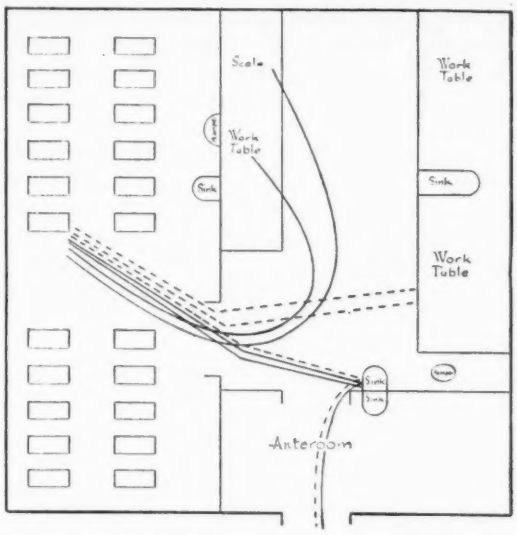


Figure I. Route taken by two nurses in giving bath, weighing and dressing one infant before simplification of technic. Broken line indicates routes taken by Nurse 1 and solid line that taken by Nurse 2.

working quite independently. When all came together—medical, nursing, and administrative staffs of the hospital, and physicians and nurses of the Department of Health—then hospital problems were analyzed more completely and solutions were more readily found. Such conferences were of little value unless all those concerned were present. It was found to be particularly important to have both medical and nursing staffs work together. Moreover a written report of findings and recommendations sent by the Department of Health to both the administrator and the head of the medical board of the hospital proved helpful.

A result of the hospital surveys was the stimulus given to hospitals seeking advice of Department of Health experts before building changes were made. The demand for hospital beds and an increased birth rate led to building of new nurseries in some hospitals. Being "in on the ground floor" with these hospitals made it possible to discuss building plans before they reached the final blueprint stage. The consultant nurse has participated in such conferences to indicate ways in which building plans can further an efficient nursing service in the hospital.

It was also evident early in the surveys that some kind of recording form would be helpful to the survey staff. This form has undergone frequent revisions. Both medical and nursing information are recorded on one form. This record has been valuable in sending out letters of recommendations to the hospital, in providing data for studies, and in giving a complete picture of the individual hospital.

WHAT WAS FOUND ON SURVEYS

In New York City 116 hospitals provide service to maternity patients; 13 are municipal hospitals, 63 are voluntary, and 40 proprietary. In the first 14 months of the program 105 were visited. This report, however, is based on the first 70 selected for visits in the beginning of the program. As varied a selection as possible was made, but preference was given to those hospitals having outbreaks of communicable disease in the nursery. One had to know what the current nursing practices were before one knew where and how to work most effectively. The chief purpose of the surveys was to stimulate the hospital staff to think through its own problems. Sometimes they did this with little outside assistance. Their interest and cooperation was always heartening. Sometimes the nursing consultant would analyze a given procedure in some detail. For example, Figure I shows the route taken by two nurses in the morning routine care of one baby in

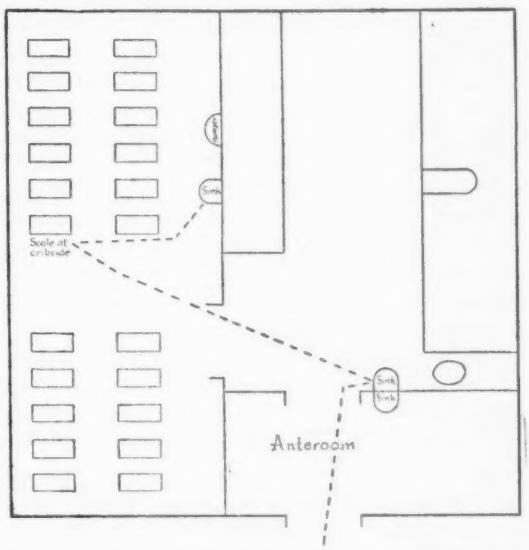


Figure II. Route taken by one nurse in giving bath, weighing and dressing one infant after simplification of technic.

a hospital. Each infant was undressed, temperature taken, removed to central table for weighing and returned to his crib by nurse No. 1. He was again removed from his crib to the central table for bathing and dressing by nurse No. 2. Figure II shows how the routine was simplified when the infant was weighed at the cribside and complete care given in the crib by one nurse. The gains in reducing the chance of cross infection and in cutting down on nursing time are obvious.

Reviews of the surveys show that the chief problems are found in six areas.

1. *Personnel.* All hospitals complained of having too few nurses. The Sanitary Code requirement that the nursing staff be under supervision of a graduate nurse was generally met. But in some institutions all care of the babies was given by non-graduate nurses, volunteers, practical nurses, or other hospital employees. The nurse supervisor was too far removed from the nursery to be of help. Staff included practical nurses with from 8 months to 2 years of training. Others had some experience in children's homes or were practical nurses with no formal training. Still others were women whose only instruction was the little they received when first employed by the hospital. Even graduate and supervising nurses were often without specialized training in newborn infant care, particularly with respect to the care of premature infants. Rapid turnover in staff was another problem, difficulties arising with regard to supervision, hours of duty, and salaries.

2. *Physical Setup.* The type of construction of the hospital was often a definite barrier to the best possible service. Some hospitals had complete, separate, and well equipped services, while others had services scattered over two or more floors, in close proximity to medical, surgical, or pediatric wards. Thus, the chance for the introduction of infection was increased. Often the chart room or nurse's desk was placed away from the nursery unit and made it necessary for the nurse to spend too much time walking to and from the nursery.

In many units handwashing facilities were not readily available, or lack of supplies, such as soap or towels, gave evidence that they were not used. In institutions that prided themselves on their technics, often a common hand towel or diaper that hung near the sink was found and this was only infrequently changed. Formula technic varied from very poor to excellent. At times formula rooms were lacking and general diet kitchens served this purpose.

Poor refrigeration was frequently encountered. For example, in a hospital visited during an outbreak of epidemic diarrhea of the newborn, the refrigerator used for storing formulas had been out of order for three days. In three other hospitals temperatures ranged from 68° to 76° F, instead of the required 50° F, or below.

Defects in regulation of temperatures in refrigerators in which formulas were stored were discovered in some of the first surveys. Often formulas stayed for hours at temperatures favoring the growth of bacteria. Therefore, checking the temperature of the refrigerator with an approved thermometer became a routine procedure. The increased load on maternity services often overtaxed refrigeration facilities.

Isolation facilities varied from complete, well equipped precaution and isolation units to any small room without handwashing facilities. Many times infants were merely kept in a corner of the clean nursery on an "isolation technic." Little attention was paid to the criteria for isolation of patients. There was reluctance on the part of the private physician to have his patient transferred to an isolation unit. It was not uncommon to find one or more patients with fever kept on the clean maternity service, even when an isolation unit existed in the hospital. The poor location and setup of many isolation units precluded their proper use. They were isolation units in name only. Their drabness, poor equipment, and location on a floor infrequently used made them of little value.

3. *Nursing Technics.* Surprisingly elaborate, unrealistic, and inefficient nursing technics were found in use. This applied both to the routines used in the care of the mother and that of the newborn infant. There was a wide variation. In some hospitals a carefully planned routine allowed the baby to be cared for on an individual basis in his own crib with little handling and a minimum opportunity for acquiring infection. In others, several infants were bathed simultaneously on one slab or table with all supplies and equipment used in common. It was also, for

example, a practice in some hospitals to use the same comb from infant to infant.

Similarly, care for mothers varied. For example, in some places perineal care was given with a common forceps used from patient to patient without adequate sterilization between each use. In others an individual sterile forceps was used for each patient.

Lack of equipment frequently played an important part in breakdown of technics. For example, it was not unusual to find insufficient thermometers. The number varied from one in an individual holder at the crib-side of each infant to one in a common holder for 13 infants. Bedpan sterilizers were frequently lacking so that there was no sterilization of bedpans between use for each patient. There was insufficient equipment for caring for soiled linen. This was frequently thrown on the floor and collected by the nurse after the morning work was done. Waste containers were often uncovered or available covers were not used. In one large institution because of lack of laundry hampers, sheets were made into bags and attached to infants' cribs to provide a means of caring for soiled linen. In some instances, technics were too elaborate and exhausting to execute, and either remained undone or were carried out haphazardly.

4. *Case History Records.* Records on babies and mothers were frequently incomplete. When an outbreak of diarrhea occurred, for example, it was usually impossible to secure even minimum data on the number and type of stools passed by the infants exposed to a known case. Sometimes on these same records inconsequential data had been recorded (such as "a.m. care given") thus using valuable staff time for recording of valueless data. Daily weights were sometimes recorded on as many as three different records. In institutions with large courtesy staffs, where no one physician was responsible for the overall service, records constituted a particular problem. Certainly with staff shortages it seemed imperative to review all record keeping procedures so that a routine could be established that could record adequately the information really useful in caring for mother and child. With simpler records, it was more probable that attention would be paid to using the data. A rise in temperature or a soft stool was too often missed.

5. *Overcrowding of Facilities.* The fifth area of difficulty was found in the overcrowding of nurseries, making it almost impossible for the nurse to carry out good technics. Under the crowded conditions, infection from infant to infant would almost certainly occur. The fundamental principles of safe care might be well known, but their application was faulty as the result of overcrowding and overwork.

6. *Instruction to Mothers.* The sixth area and one of particular importance to public health nurses was the passing unnoticed of rich opportunities for teaching mothers during the lying-in period.

Some hospitals gave mothers instructions in infant bathing and formula preparation, but few felt any responsibility for teaching mothers how to handle, or to nurse and bottle-feed their babies. Bottles were almost invariably propped in cribs for feeding, and infants were infrequently taken to their mothers. Even if one disregards entirely the psychological implications of this separation of mother and baby, one cannot overlook the fact that mothers are not even taught the simplest principles of safe and clean physical care of infants. The hospital may take every precaution itself during the newborn period and then send a mother away completely ignorant of how to do the simplest things for the infant. One cannot help wondering whether some of the illness which so often occurs in the young infant could not be prevented by better teaching in the hospital. For example, during the inspection of one hospital, a mother and her infant were being taken in the elevator by a nurse to the discharge desk. As the elevator reached the street level, the mother, probably realizing for the first time that she was soon to be left alone with her infant, turned to the nurse and said, "What shall I do with the baby when I feed him? Hold him, or put him on the bed?" What a valuable opportunity had been lost to teach this new mother!

Hospital personnel unfortunately are not usually aware of what happens when the mother leaves the hospital. Few hospital nurses have had the opportunity to see what the return home means to the mother, baby, and family. Therefore, far too few are instrumental in effecting a tieup with a community nursing service upon discharge.

TABLE 1. UNSATISFACTORY CONDITIONS FOUND IN 70 HOSPITALS INSPECTED, NEW YORK CITY, 1944-1945

Conditions found	Hospitals in which specified condition was found	
	Number	Percent
Formula preparation		
Questionable aseptic technic	70	100
Formula not nippled and capped	62	89
Propping bottles for feeding infants	69	99
Superfluous nursing procedures		
Daily skin care of infants	67	96
Breast care before each feeding	66	94
Daily weighing of infants	57	81
Temperatures in infants 2, 3 and 4 times daily	26	37
Sub-standard technics		
Central table care of infants	62	89
Inadequate scale drape	56	80
Common perineal supplies	54	77
Mothers' hand care before handling infants		
Alcohol sponge	34	49
None	5	7
Wiped with wash cloth	5	7
Common carrier for transportation of infants to mother	8	11
Insufficient equipment		
Insufficient forceps for perineal care	54	77
Insufficient thermometers for each infant	33	47
Crowded nurseries	36	51

There seems to be a feeling among some nurses and physicians that private patients do not need instruction. There is also some reluctance on the part of the physicians to utilize the services of the public health nurse in helping the new mother to care for her infant and in making adjustments in the home. Physicians and families have not yet entirely accepted the educational functions of the public health nurse.

SUMMARY OF RESULTS

In reviewing the results of the 70 hospitals surveyed so far it is of interest that many problems appeared over and over again. These were important in that they made for possible spread of infection, and also consumed nursing time that could have been used to better advantage. See Table 1.

Return visits have been made to 52 of the 70 hospitals just mentioned. The amount of time the Health Department staff had worked with each hospital varied. If the hospital had a record of frequent outbreaks of diarrhea, more time was spent with it. Some hospitals requested more time; others were actively trying to get permits renewed and needed more attention. A comparison of what was found at the time of the first visit and on a subsequent visit made from 1 to 10 months later is seen in Table 2.

Careful examination of Table 2 shows that a decided improvement had been made in many important items of technic. For example, the individual care in the crib established in 22 hospitals has undoubtedly reduced the chance of spreading infection in these hospitals. Having formulas properly nippled and capped in the formula room at the time of preparation has not only made for a safer technic but has saved valuable time for the nursery nurse. Additional time would have been saved for the nurse in many hospitals had daily weighing and elaborate bathing of infants been discontinued. The strict adherence to certain of these rituals undoubtedly diverts attention from more important and fruitful tasks. Moreover, a false sense of security develops, particularly in the nursery, and the alertness to breaks in technic is too often dulled.

It is of some interest that those technics

TABLE 2. CHANGES IN CONDITIONS FOUND ON FOLLOW-UP REVIEW OF 52 HOSPITALS, NEW YORK CITY, 1944-1945

Conditions found	Hospitals in which specified condition was found			
	First inspection		Second inspection	
	Number	Percent	Number	Percent
Formula preparation				
Questionable aseptic technic	52	100	49	94
Formula not nippled and capped	46	88	24	46
Propping bottles	51	98	51	98
Superfluous nursing procedures				
Daily skin care of infants	50	96	42	81
Breast care	50	96	45	87
Daily weighing	42	81	37	71
Temperatures 2, 3 and 4 times daily	20	38	7	13
Improper technics				
Central table care of infants	45	87	23	44
Inadequate scale drape	42	81	22	42
Common perineal supplies—one forcep	38	73	27	52
Common carrier	7	13	3	6
No hand care of mothers	4	8	3	6
Alcohol sponge used hand care	26	50	25	48
Hands wiped with wash cloths	3	6	3	6
Insufficient equipment				
Insufficient forceps	38	73	27	52
Insufficient thermometers	25	48	18	35
Crowded nurseries	28	54	23	44

in which the nurse alone was involved (draping of scales, where baby is cared for) were more easily changed than those technics in which the physicians' orders were involved (weighing, bathing).

COMMENT

It must be emphasized that the evaluation of individual items of the kind just discussed is not an end in itself. It does serve, in our experience, as a way of pointing to weaknesses in the total picture and to arousing the medical and nursing profession to the necessity of continuing day by day scrutiny of all technics used on maternity and newborn services. Such awareness and willingness to analyze repeatedly the problems in the individual nursery, ward, formula or delivery room, brings improvement in services.

A careful study of the individual infant and mother and their course through the hospital from the moment the mother is admitted is another way to find important breaks in technic and to stimulate hospital staffs to analyze their own problems. Our observations give evidence that important leads in the epidemiology of infantile diarrhea are in a study of both mother and infant. Our surveys have indicated the need for more complete admission histories with specific reference to diarrheal disorders in the mother at or just prior to admission to the hospital.

Improving hospital technics so as to reduce the chance of cross infection and to save time for the nursing staff has been the chief object in our efforts so far. The immediate situation has demanded this approach. As has been emphasized long ago by us[6] and also by Watt,[7] it is evident that there is much more to be done to make the delivery of the newborn infant in the modern hospital a satisfactory one from the point of view of the mother and child. The life in a large congregate nursery can probably never be made satisfactory from the point of view of the newborn infant.

It is not only in the prevention of the spread of disease, however, that maternity services in modern hospitals need improvement. Many psychiatrists are pointing out the emotional difficulties arising out of separation of mother and child in the newborn period. Certainly the mother has little opportunity to learn how to care for her infant or even

(Continued on page 344)

Florence Nightingale and Public Health Nursing

By CHARLES-EDWARD A. WINSLOW, Dr.P.H.

THE ENVIRONMENT into which Florence Nightingale was born, 126 years ago today, was in some respects a very fortunate one. Her family was in comfortable circumstances, with two country houses; and in addition to the normal accomplishments of her sex and class—music and the capacity to do fancy work—her father gave her some training in Greek, Latin, and mathematics. For the career of a nurse, to which she early aspired, the background was less favorable. In these days, a young lady of family was supposed to be, or to appear to be, "artless and docile, with a capacity to faint on appropriate occasions." The idea that such a tender female should actually perform the menial tasks of nursing was horrifying. After many years of longing for such a career, Florence asked Dr. Howe, the husband of Julia Ward Howe, "Would it be a very dreadful thing to study nursing?"

This was no swooning damsel, however. She did delay for years in deference to her parents, but finally took the decisive step. She went for her training to Kaiserswerth on the Rhine, visited the French hospitals, and established a nursing home for gentlewomen in London.

From this still moderately respectable post she was called by Sidney Herbert in the War Office to deal with the scandal of the Crimean hospitals which was reverberating in the British press. Four miles of wounded soldiers were crowded in those barracks, 18 inches apart. They lay in the fever ward on the floor or on straw pallets on wooden divans. The floors were saturated with filth and alive with vermin. "There were no vessels for water, or utensils of any kind; no soap, no towels, or cloths; no hospital clothes; no chairs, tables, benches, nor any other lamp or candlestick but a bottle." In three months, 132 towels had been washed for 2,000 patients.

Into this inferno came Florence Nightingale, with 38 selected nurses, on November 4, 1854. She cleaned up. She started diet kitchens. She bullied the resentful military officials into giving her supplies. She bought others with her own funds. She somehow found knives and forks, toothbrushes, and other necessaries. In February 1855, the death rate in this hospital was 420 per 1,000; in June 1855, when Florence Nightingale returned to London as a national heroine, it was not 420 but 22.

What manner of woman was this who wrought such miracles in the Crimea? She was best known as the "Lady with the Lamp" who brought a glow of comfort to the suffering boys as she passed through the wards at night. One of them wrote, "What a comfort it is to see her pass even. She would speak to one and nod and smile to as many more; but she could not do it all, you know. We lay there by hundreds, but we could kiss her shadow as it fell, and lay our heads upon the pillow again content."

But Florence Nightingale was much more than a ministering angel. She had more to give than a smile. She was an executive of the first order and a valiant fighter for the cause. Sir Edward Cook says she had "a hard head, a soft heart, strongwilled, high ideals, inclined to be demanding on others less able to be strong. . . . An equal contempt for those who act without knowledge, and for those whose knowledge leads to no useful action." She was the "Lady with the Broom" as well as the "Lady with the Lamp."

She had even more to give than sympathy and energy. Her energy was directed by constant and rigorous scientific criticism. The knowledge of sanitation a century ago was incomplete by modern standards. It included no recognition of the microbe, but it had cor-

rectly grasped the broad generalization that dirt and disease were intimately related. What was known at the time, Florence Nightingale clearly understood. Above all, she checked all her efforts by statistics, with a scientific caution far ahead of her time. She was, in spirit, the "Lady with the Slide-Rule," as well as a lady provided with the lamp of compassion and the broom of efficiency.

If Florence Nightingale's life had ended in 1855, she would have been a historic figure for all time. But she lived on till 1910. For much of the time she was an invalid confined to her room; but from that room she wielded a power which penetrated to the far corners of the Empire. Queen Victoria said once, "Such a head! I wish we had her at the War Office." In the long years of invalidism she laid the foundation of mighty reforms and in three different fields she initiated movements which carry on her indirect influence today in a way which affects the life of mankind in a far more vital fashion than even her personal achievements at Scutari.

The first of these contributions was in the field of improvement in hospital construction. John Howard had stimulated interest in this field at the end of the Eighteenth Century; but, in the Nineteenth Century, Florence Nightingale's *Notes on Hospitals* and many of her shorter publications accomplished wonders for hospital reform. She argued with power and passion for adequate water supply and waste disposal, for cleanliness of the wards and the bedding, for control of overcrowding, for heating and ventilation, for lighting, for adequacy and sanitation of food supplies. She fought for all these things in England; and, by so doing, she made the way easier for such men as Goldwater half a century later in the United States. The hospital administrator of today—whether he is conscious of it or not—is building on the foundations laid by Florence Nightingale.

The second area of public health practice which will always bear the impress of this great pioneer is military medicine. Almost at once upon her return from the Crimea she was appalled by the conditions which affected the British Army in India. She secured the appointment of a Royal Commission to study the problem and prepared questionnaires which were sent to every station, and the results of which she analyzed herself. Not a single one of the stations was found free from sanitary defects. The final report of the Commission embodied all of her recommendations with regard to camp sanitation and military hygiene; and, as a result, the death rate for the army in India was cut from 69 per 1,000 to 35. It has been truly said that this was "a complete example—history does not afford its equal—of an army, after a great disaster arising from neglects, having been brought into the highest state of efficiency." It was at Florence Nightingale's suggestion that an Army Medical School was established, providing for the first time training in hygiene and sanitation. I doubt if General Simmons and the other leaders who planned the health program which so successfully protected our soldiers in Asia and Africa and Europe thought of their debt to Florence Nightingale; but their task would have been much harder without the background of the years of progress along the lines she traced.

Finally, the greatest of all living monuments to the "Angel of the Crimea" is the profession of nursing—and, particularly, that branch of it which functions in the field of public health. When she began her career, it was "a very dreadful thing to study nursing." Aside from the devoted work of the religious orders, nursing was a menial occupation. The glowing example of Florence Nightingale transformed it into an honorable profession. By her establishment of the first modernly-conceived training school for nurses at St. Thomas's Hospital, she set the example which was followed by Bellevue Hospital in 1873 and initiated the movement which led straight on to the university schools at Western Reserve and Yale. Her contributions to hospital administration and to military medicine were important and vital, but she created the profession of nursing almost singlehanded.

Furthermore, from the beginning, she visualized the nurse not merely as an attendant on the sick but as a teacher of hygiene. She described the nurse as a "health missioner," a guide and teacher of health to the individual in the home. She recognized that "from the very nature of the case, compulsion can under no conditions work the changes we want to see wrought by the obedience of consent."

She demanded a trained medical officer of health in each area (an end not yet attained in one third of the counties of the United

States) with trained sanitary inspectors and "health missioners." She cooperated actively with the county of Bucks in setting up special training for such teachers. The duty of a district nurse, as she conceived it, was first to care for the patient and second to care for the house and home, teaching how to render it more healthful.

Here was the conception of the public health nurse in its vital essence. It is beyond question her inspiration which has placed the nursing profession in the forefront of social consciousness with regard to the broader and more constructive meaning of the word "health" or "wholeness" and not merely the freedom from disease. We may well be proud of the way in which her challenge has been accepted in the United States. I think it was Dr. Welch who once said that the chief contributions made to the cause of public health in the United States had been the Panama Canal and the public health nurse. The flame which guided Lillian Wald and Adelaide Nutting and Annie Goodrich and all the rest of our great nurses was lighted from the lamp of Florence Nightingale.

In her day, this great pioneer had to contend with a form of religious determinism which tended to stifle every effort at reform. She says in her *Notes on Nursing*, " 'With God's Blessing he will recover' is a common form of parlance. But 'with God's Blessing' also, it is, if he does *not* recover; and 'with God's Blessing' that he dies, if he does die. In other words, *all* these things happen by God's laws, which *are* his blessings—that is, which are all to contribute to teach us the way to our best happiness. Cholera is just as much His 'blessing' as the exemption from it. It is to teach us how to obey His laws, which are at once our means and our inducements to advance towards perfection. 'With God's Blessing he will recover' is a common form of speech with people who, all the while, are neglecting the means on which God has made health or recovery to depend."

We are at present confronted with a gospel of resignation somewhat similar to that which Florence Nightingale deprecated Only today it is the God of laissez-faire who is invoked to stop all rational progress. We have indeed accepted the fact that the physical universe is controllable, that a water purification plant represents a law of nature just as truly as a typhoid germ. In the social and economic field, however, we are told that all will be well if we let everything alone—that the unrestricted conflicts of individual selfishness will, by some magic produce a good life for all—that, according to Hayek, intelligent cooperative planning is the "road to serfdom." Florence Nightingale's combination of faith and common sense would have played havoc with such mystical dreams. She knew that we live in a physical world that is in large measure controllable by the application of the human mind and will; and that it is our prime duty as individuals to learn how to effect such controls and to apply that knowledge. She would be equally sure today that the economic and social levels of this world will not yield to absent treatment. Economic laws are, in themselves, no more essentially beneficent than physical laws. Both may be utilized for our common good, but only by the intelligent and vigorous application of the human mind and the human will to the tasks of the common welfare. As she planned and worked for the Crimea, for the hospitals, for the army, for the nursing profession, so we must plan and work for the world of tomorrow.

Presented at the Florence Nightingale Honors Day Ceremony, Town Hall, New York, May 13, 1946. Delivered, in the absence of Dr. Winslow, professor emeritus of the Yale School of Public Health, by Dr. Hugh Auchincloss, Presbyterian Medical Center, New York. On this 126th anniversary of the birth of Florence Nightingale, a memorial chair in her name was unveiled as a tribute to all members of the nursing profession. Dedication of the chair was made by Gertrude Lawrence, well known actress, with the reading of Longfellow's poem, "Santa Filomena." The unveiling was performed by Miss Lawrence with the assistance of Annie Warburton Goodrich, dean emeritus and founder of the Yale School of Nursing. Also speaking on the program were Mrs. August Belmont, Mrs. James H. Van Alen, and Miss Goodrich. The meeting was sponsored by the Board of Trustees of Town Hall in cooperation with the Town Hall Historical Committee, of which Mrs. Van Alen is chairman.

UNRRA Nurses in Europe 1946

By LILLIAN J. JOHNSTON, R.N.

UNRRA NURSES, six hundred and twenty of them from sixteen different nations, had been actively engaged in Europe and the Middle East for many months and the time had come for personal visits from Headquarters and the European Regional Office. In October 1945, Florence Udell, chief nurse in ERO, and I set out to see, in detail as far as possible, the actual nursing operations of our missions in that part of the world. Our journeyings took us well into March 1946 and, although snow, ice, and "low ceilings" did contribute to the length of our stay on the continent, we were able to see a large proportion of UNRRA nurses at work in Italy, Egypt, Greece, Yugoslavia, Austria, and Germany. We did not visit Poland or Ethiopia where the nursing programs have been under way for a much shorter period but nurses in those missions too are filling a real need and a report on their work will follow in due time.

Before reporting on the work, country by country, we should like to convey our deep appreciation to the professional nursing groups of all of the contributing countries for their unselfish assistance in providing UNRRA with so many of their most able colleagues. In every country we visited it was evident that the high calibre of personnel was the decisive factor in spelling success or failure in our attempts to help the liberated countries in the reestablishment of their nursing services. UNRRA nurses were usually on the spot before supplies and transportation, and other facilities considered essential to any program, and it was up to the nurse to make herself useful from the start by "making do" with little or nothing. That she was still able to give encouragement and new spirit to the nurses who had suffered so much during the war years only emphasizes her essential worth.

Miss Johnston is a senior nurse officer (R) of the United States Public Health Service and chief nurse of the United Nations Relief and Rehabilitation Administration.

THE FIRST mission on our list was Italy—partly because that country was on the direct route to the Balkans and Egypt and partly because some of the preliminary work there was completed and decisions regarding transfer of personnel to other missions were necessary. In Italy there were two distinct programs in operation; one being concerned with the care of "displaced persons" in camps situated in southern Italy and the other with surveys of nursing needs throughout the country in both the hospital and public health fields. Many of the young nurses originally assigned to the Philippeville project in North Africa were transferred to the displaced persons program in Italy and we were impressed with what imagination and youthful energy can produce in a situation that would try most of us with far wider experience. We spent some days in all of the camps observing the work in camp hospitals, clinics, delousing units, nursery school and child feeding programs, public health nursing and the teaching and supervision of nurse's aides. The last mentioned project is an UNRRA "must" in most operations. With the great shortage of professional nurses in all European countries today, UNRRA could never have given care to the large numbers of persons for whom it has been responsible without the use of nurse's aides selected from the displaced persons and taught by our nursing staff. The lesson plans worked out by Ruth S. Faust, who is loaned to UNRRA by the Near East Foundation and was literally the first UNRRA nurse in the field, have served as a guide in all of our planning. Adaptations to fit the varied situations have been necessary but the fact that Miss Faust worked the plans out "on the ground" makes them ever so much more useful than

Understanding one another is a major problem at El Shatt, UNRRA's refugee camp near the Suez where there were 28,000 Yugoslavs living under canvas. The majority speak no English and little French, so Dorothy Sutherland, of Minneapolis, who is lecturing on child welfare to a group of Yugoslav refugee nursing aides, needs an interpreter. Nina Solon, of Sarajevo, who speaks fluent English and is in great demand, translates Miss Sutherland's words into Serbo-Croat.

would anything we could have sent from our more complicated home situations. Improvisation was the watchword and one was not surprised to see in the Italian Camps the same sort of thing seen in the Middle East Camps a year ago. Evaporated milk cans were still being cut off, the edges smoothed, handles of spare tin nicely wrought, and providing cups for hospital patients. In one camp hospital there was a flourishing occupational therapy program which used a surprising number of odds and ends to make really attractive toys for the nursery school group. In that hospital were a variety of patients, again testing the resourcefulness of the nurses. One ward held two Ethiopians, some Polish Jews, some Yugoslavs, and one Chinese.

One of the newer developments in the camp nursing setup at the time of our visit was the introduction of qualified Italian nurses to assist in the program. Our nurses insisted that the Italian nurses be billeted with them so that they could share each other's viewpoints and language. It was indeed a pleasure to sit down at table with the camp medical and nursing staff—British, American, Canadian, and Italian, and find that language posed no real problem. Plans were under way to take over more camps in the north of Italy and the nursing staff was to be shared in the two areas.

The overall Italian nursing program was set up with a chief nurse, and five regional nursing consultants, all well qualified public health nurses. The regional personnel were assigned to Rome, Sardinia, Sicily, Florence and Naples. A large proportion of their time was spent in assisting with a survey of the need for and supervising the distribution of medical and nursing supplies. This could not be considered public health nursing consultation per se except as it provided opportunity for knowing and working with the leaders and staff of the Italian nursing profession. The chief medical officer, when the question of time spent on medical supply requirements was discussed, said, "It certainly isn't straight public health nursing but I can't think of anyone who could have done the job with more intelligence and dispatch and it had to be done then with the people at hand." Flexibility has been a

All dressed up and with some place to go, Yanni, Kosta and Aleko arrive at the Sikiaridion Preventorium in Marousie, near Athens with Nurse Lois Goodell. Here they will be given a warm comfortable home, fresh air and good protective foods to prevent their developing the tuberculosis with which they are threatened. Nurse Goodell, who comes from Lorain, Ohio, is one of the United States Public Health Service Nurses who have been lent to the UNRRA Mission in Greece.

basic requirement for appointment to the UNRRA nursing staff and no trait has been more often tested. As has been mentioned, this activity served as a tool to get into the field with the Italian supervising nurses, many of whom had not visited their districts for over a year because of lack of any sort of transport.

OUR NEXT CALL was Egypt where we were gratified to find a diminishing program which was being operated with a minimum of confusion. On my visit to this mission a year ago I hoped, but could not actually foresee, that the refugees would be returned to their homes with provision for needed nursing care en route. Practical planning by Margaret Arnstein and her staff, well in advance of the actual movements of large numbers of persons, including those who were bedridden, is responsible for an extremely difficult job being so capably handled. At the time of our visit in late November, the refugee population had dropped to about 9,000 Yugoslavs and 2,000 Greeks. We were still operating a small camp for about 500 Royalist Yugoslavs at El Arish near the Palestine border but the largest group was at El Shatt down on the Sinai Desert. Three of our public health nurses were, at the time, in British East Africa, each one on her own and quite isolated. They were doing a pioneer job, assisting in assembling Greek refugees scattered over the area for transportation to El Shatt for the return journey to Greece. There was considerable illness including much malaria and need for health measures such as immunization. Reports since that time indicate that public health nurses again proved their worth.

In the repatriation of this large group of refugees, so-called "Flight Teams" were organized. At least one and often several nurses were required and, in addition, UNRRA trained nurse's aides who were being repatriated at the same time worked on board ship supervised by the UNRRA nurses. Sick bays, dispensaries, milk clinics for formula babies and children up to 3 years were provided with supervised nursing service. Helen Johnson, chief nurse of the Middle East Office at the time of our visit, reported that she never lacked for volunteers for flight duty even though there was very real danger involved in every trip. The UNRRA staff was the

small steadying influence in large groups of people of varying ages and varying degrees of health. The bravery of Arlene Waldhaus, USPHS, junior assistant nurse officer (R), in the fire on the "Empire Patrol" in the Mediterranean for which she was decorated by the U. S. Army, is an example of what might have occurred on any "flight." Steady repatriation efforts will shortly reduce our once large Middle East nursing staff to zero. Some of the nurses will come home after over two years' service and some of them will be transferred to other missions.

Athens was our next port of call and since the article by Olive Baggallay, chief nurse, which appeared in *The American Journal of Nursing* for April 1946, covered the UNRRA nursing program in Greece so very well, I shall mention only a few of our impressions gained in a three-weeks visit in early December 1945. In the early days, American and Canadian nurses outnumbered all other nations in the Greece Mission Nursing Section. This came about only because the staff was recruited during wartime and the United States and Canada seemed to be best able to spare public health nursing personnel. At the time of our visit, the nursing staff was gradually becoming more international in character and included more British nurses, some Danes, some New Zealanders, and others. To quote from Miss Udell's report:

> It is impossible to find words to express adequately the pleasure and admiration we feel after seeing the work being carried out by the Nursing Section of the Greece Mission under the magnificent leadership of Miss Baggallay. There was no problem of poor morale for us to solve, no question arose as to the utilization of nurses, and, apart from a few minor personal problems, our whole time was spent in observing the way in which the nursing program was being organized and in discussing further plans. On a week's field trip into the country, I met seven UNRRA nurses and had an opportunity of talking with them and seeing something of their work. I was much impressed with their general ability and their eagerness to carry through the job in hand based on true UNRRA principles—to gain the cooperation of the Greeks and to leave behind something with which they can carry on after UNRRA personnel leaves the country. To judge from the conditions seen, the difficulties must have seemed insuperable when these nurses first arrived in the country but it is obvious that their efforts have been untiring and inspiring and that great improvements have been made in the nursing care given to the people, both in hospitals and the field of public health.
>
> I cannot speak too highly of the whole staff of the Nursing Section of the UNRRA Greece Mission. I have had the privilege of seeing fifty percent of the staff and hearing of the work of others and reading their reports. Not least am I impressed by the truly wonderful international relationships they have established among themselves and with their Greek colleagues.

IT SO HAPPENED that, at the time, the most efficient way for us to get to Belgrade from Athens was to return to London and start out again. This provided opportunity for a few days in London to start action on problems met in the field up to then and to acquaint ourselves with new developments there and at Headquarters. The flight to Vienna en route to Belgrade was made by way of Hamburg and, as a glance at the map will show, it was a little less than directly east from London. We arrived safely, however, in a blinding blizzard. Our stay in Belgrade was a short but very worth-while one. Difficulties in communication had kept us rather poorly informed as to detailed activities in the Nursing Section and, in any case, a personal visit is so much more informative. For many reasons, none of them inherent in the nursing program, we had not been able to follow through on our original plan for assistance to the nurses in Yugoslavia. We had planned a setup similar to the one in Greece. We have had, however, a small staff of well qualified consultants in the country for some months working under the able leadership of Therese Kerze, nurse officer (R) USPHS, an American who has the special advantage of being able to speak the language fluently. Since difficulties precluded nursing participation on a regional level as in Greece, the nursing staff set out to contribute in other ways. Assistance in securing textbooks, teaching materials, and equipment for nursing schools, in planning curricula, in encouraging the Yugoslav nurses to reestablish their professional associations and in encouraging continued nursing supervision of the Bolnicarke (nurse's aides whom we trained on the desert in Egypt). Assistance in the teaching of nutrition has been provided by Frances Frazier, senior assistant nurse officer (R) USPHS, who has had special preparation in that field.

A "team" of doctors and nurses, skilled in plastic surgery and trained under Sir Harold Gillies in England, was brought to Belgrade under UNRRA auspices to give specialized training to Yugoslav personnel. The Nursing Section has advised the group and actively participated in the work of securing qualified nursing personnel to staff the hospital in which the demonstration was to take place. One of the UNRRA consultant nurses was assigned to organize the teaching of ward administration. Miss Udell and I visited the hospital and observed the first "all Yugoslav" operation with teaching doctors and nurses watching through the glass partition of the operating theater. War injuries fill a large hospital in Belgrade with excellent teaching material for such a project.

THE AUSTRIAN MISSION, with headquarters in Vienna, was concerned with two problems when we arrived there in mid-January. Our first responsibility had been toward the displaced persons in the French, American, and British zones but since Austria had been designated a liberated country, our interest was then spreading to the Austrian population as well.

In the Displaced Persons Operation, the UNRRA nursing staff has been widely international from the beginning. In the administrative setup in Austria the chief nurse, C. Grant-Glass, is a Scot. She has three deputies: one Belgian, Mlle. Daman for the French Zone; one American, Rose Nabors, senior assistant nurse officer (R) USPHS, for the American Zone; and one Australian, Edith Butler, for the British Zone. UNRRA has no operation in the Russian Zones of either Austria or Germany. On the team or local level there are Dutch, Belgian, French, Danish, Norwegian, British, Irish, Austrian, and American nurses.

We visited many camps and saw at first hand how the nursing program was going. Again, evidence of the resourcefulness of public health nurses was at hand. They had found, among large mixed populations, all available qualified nurses, all partially trained nurses, and all potential nurse's aides. In each of the categories, they had prepared them for work in the camps and, by the time we arrived, the original "one" camp nurse had a staff carrying on in sick bays, in public health nursing programs including large scale immunizations, chest x-rays, infant and child hygiene and antepartum clinics. In short, we found the nursing services one would expect in a community of comparable size.

In cooperation with the nurses assigned to Military Government in the United States and British Zones, Miss Grant-Glass was making plans for UNRRA assistance to Austrian nurses.

AUSTRIA IS a far smaller country than Germany and, even in the limited time at our disposal, we were able to visit most of the camps. By planning group meetings, we were able to meet and talk with all of the nurses. The nursing program for Displaced Persons Operations is essentially the same in both countries. Although we saw relatively few camps in Germany, we did manage to meet and talk with most of the nursing staff there. This rather large undertaking was accomplished by arranging for all-day meetings in the various district offices. Both British and U. S. Zones are set up for nursing supervision on a district plan. For many of the team nurses it meant starting out from camp in the very early hours of the morning and travelling in "1500 weights" over icy roads. They volunteered, however, that it was worth all that and more to be able to meet their colleagues, discuss common problems, and get away from the immediate job for a day. Lack of adequate transport has been one of the major problems in D. P. Operations in Germany and the UNRRA nurses have had to do pioneer jobs pretty much by themselves for long periods of time. Germany was not a cheerful place this past winter and it is to the credit of the staff that they stood it so well. In the U. S. Zone, we held meetings in Bamberg, Regensberg, Munich, Stuttgart, and Wiesbaden. In the British Zone, we met at Bunde, Plon, Wunsdorf, and Iserholn. The chief nurse in the American Zone was Bertha Tiber, nurse officer (R) USPHS, and in the British Zone, Lyle Creelman, a Canadian. At the time of our visit, we could not enter the French Zone and Miss Udell expected to return at a later date. Nurses at team level represented the nations mentioned for Austria.

One of the really beneficial effects of such international team work will be the breadth of understanding which has developed. It seemed unnecessarily hard at first to have UNRRA nurses teamed up in groups with no

Some D.P. children in Salzburg, Austria. Shown with four other UNRRA nurses, Miss Johnson is in center forefront.

common language when the responsibility was so great. We, as nurses, still feel that more wisely selected teams (as to language) would have eased the hard road ahead immeasurably. We must admit, however, that the result we saw after eight months of operation was good.

One of the statements made most frequently by nurses of all nations was, "Now that we have worked together and gotten to know each other we can never again feel that our countries are too far apart to make interchange and real friendship impossible." Fifteen hours flying time from Scotland to New York makes the above statement doubly true.

Health Legislation

(Continued from page 322)

method of expediting this program would be through intensified training of approximately 800 able and experienced nurses, who in turn would serve in a teaching and consultant capacity to training centers and health agencies in the special fields of maternal, pediatric and orthopedic nursing.

To conserve this nation's most precious resource—a strong citizenry—necessitates comprehensive action at its source, the protection of the mother and the infant of today.

Through the 16,200,000 visits made each year to the homes of our people, public health nurses are in a strategic position to know tragedies that often occur because of lack of medical care.

Concluding the report were some 20 unedited case stories received from communities all over the country, which demonstrated the need for, the value to, and the right of every mother and child to complete health and medical service of good quality.

We Put On An Exhibit

By ELIZABETH H. RATH, R.N.

THE 1946 "Know Your Public Health Nurse Week" Program in Pittsburgh, Pennsylvania, was focused around an exhibit held in the beautiful Buhl Planetarium. The exhibit was shown for six days and had a clocked attendance of 5,174, an average of 862 people per day, all of whom paid the 10 cents admission which is the regular charge to enter the Planetarium.

Because exhibits are a form of publicity which public health nurses consider during every publicity campaign, we thought our experience would point out some facts which might be helpful in deciding whether or not an exhibit is worth while.

Our community is large. Greater Pittsburgh has a population of approximately 1,900,000. Its hilly topography and transportation difficulties have led to the development of many widely dispersed, self-contained communities, each with its own newspapers, banks, school systems, and general community activities.

Some of the public health nurses serve a limited group and area, such as the school nurse in an independent school district or a visiting nurse employed by a small community. Some public health services cover the entire Greater Pittsburgh area, such as the Tuberculosis League and the Pittsburgh Public Health Nursing Association. There are at least fifteen separate agencies carrying on some form of public health activities.

The state, city, school, industrial, and visiting nurses wear different uniforms or no uniform at all.

Our problem then was how we could bring all these nurses and services, operating singly or cooperatively, from widely scattered centers into one unified publicity program so the public would have a clearer conception of the public health nurse and her activities.

Activities! There was our answer. Concentrate on publicizing the nurses' activities rather than the variety of agencies. If we could jog the public's mind from its erroneous association of public health nurses with only poverty, slums, and quarantine enforcement (which we know to be a common belief through personal experience, polls, questionnaires, and other means) we would consider our efforts worth while.

An exhibit of activities might do it. Public health nursing activities fall into specific groups — prenatal, postoperative, industry, school, and the like. Why not build up an exhibit showing these activities throughout the life cycle. It was a natural!

We divided the activities into fifteen groups and selected a dramatic or interesting feature of each to exhibit. No attempt was made to tell the whole story of any service or agency.

The caption above each booth served to unify the whole exhibit and associated the title Public Health Nurse with every activity by uniform signs, such as "The Public Health Nurse and Cancer Control," "The Public Health Nurse and Disease Control," and "The Public Health Nurse and Care of the Sick." Also, but less conspicuous, was a smaller placard listing the agencies which participate in such a service and another placard giving a few facts relative to it. These were all standardized. The agencies were permitted to use other individual posters and, as nurses will, tried to tell too much and tell it badly with some of them.

The booths were manned cooperatively by nurses from the agencies carrying on the indicated activity. They were assisted by lay committee and board members, Red Cross volunteer nurse's aides, and Red Cross staff assistants.

Miss Rath is director of nursing activities, Pittsburgh (Pennsylvania) Chapter, American Red Cross. She was nurse chairman of Know Your Public Health Nurse Week.

These posters greeted visitors

Briefly the exhibits were:

Care before the baby comes
- Birth Atlas displayed and discussed
- Registration for mothers and fathers prenatal class.
- Literature

Home Confinement
- Bed prepared for home delivery
- Instruments used by doctor in delivery
- Literature

Care after the baby comes
- Demonstration of baby bath with mannequin mother
- Layette
- Demonstration of kite diaper
- Scales on which visitors could weigh their babies
- Literature

Mother's Milk Registry
- Equipment for collecting, freezing and distribution of human milk
- Literature

Pre-School
- Toys, games and books for mental, emotional and physical development of child
- Literature

Care of the Sick in the Home
- Portable Incubator
- Equipment of the loan closet
- Gatch bed
- Apparatus used in home rehabilitation of accident cases and cripples
- Literature

School Nursing
- The locally famous "Happy"—a puppet show used in teaching dental hygiene
- Scales on which visiting children could be weighed
- Literature

Industrial Nursing
- First aid station for visitors (Yes, it was needed)
- Display of literature showing the varieties of health activities promoted by industries
- Literature

Disease Control
- Free vaccinations, Schick Tests and Tuberculin Tests
- Literature

Nutrition
- Adult scales for visitors
- Diet lists for overweight and underweight

AN EXHIBIT

Food chart
Literature

Cancer Control
Posters and literature

American Red Cross Home Nursing
Improvised equipment for home care of the sick (The most popular booth)
Literature

Tuberculosis Control
A poster of a very happy man with an x-ray picture of his chest flashing on and off

At the booth, visitors were sent to another room for a free chest x-ray on the modern portable x-ray machine. 978 x-rays were taken
Literature

Venereal Disease Control
Free Wassermann tests
Literature

Nurse Recruitment Booth

Below are two views of the most popular exhibit— improvised equipment for home care of the sick

State Department of Health nurses and volunteers helping visitors fill out form for free chest x-ray—985 were taken in 6 days

There were also free health movies at the Planetarium and applications were taken for future showing of available health movies to club groups. During the week 41 health films were shown to an approximate attendance of 4,976 in other parts of the county.

Newspapers were generous with space and pictures, the broadcasting companies with spot announcements, the department stores with loan supplies and publicity through their advertisements. All this suggests time, energy, courage, and money—right you are!

It took courage on the part of the lay chairman and nurse chairman to accept their appointments, for neither believed much in the efficacy of publicity. One was tied down with a family and a heavy social program, the other with a full-time job.

It took courage to attempt to bring all the public health nursing groups together for one common purpose. It had never been done before with these groups and the response and cooperation were among the many encouraging surprises we had.

It took courage to approach so formal and beautiful a building as the Buhl Planetarium and expect space for amateur exhibits, but here came our second surprise—the manager said, "Yes indeed, we will be glad to give you space. People are interested in health. The best attended exhibit we have ever had was the health exhibit following the last World's Fair."

Much the same attitude was expressed by the city editors, radio commentators, medical society, and the Chamber of Commerce.

It took courage to make the rounds of the many advertising display companies to ask for volunteer expert advice and guidance in setting up an exhibit, but we got it too.

And as for time—we know no way of computing the time the nurses and assistants spent in putting on the exhibit, but it was plenty. The nurse chairman was granted time from her regular duties by the Red Cross and spent approximately one month's time in making contacts and arrangements to say nothing of the hours all the other nurses took from their crowded schedules to get the exhibit set up and manned.

Lack of time did not permit enlisting the help of more lay people. Most of those we approached were involved in other programs set up many months ago.

Time did not permit the best use of the doctors who helped during the exhibit. Vaccinations were done between 4 and 5 p.m., blood tests between 7 and 9 p.m. Had they all been given during the same hour, it might have been an inducement for the entire family to avail themselves of the services.

Many publicity opportunities were lost for lack of time. One major newspaper was intrigued by the suggestion that a series of articles featuring the history, development, and plans of the three largest public health nursing organizations be featured, but he should have been approached two months earlier. The best publicity resulted when we wrote the facts and planned arrangements for pictures, but lack of time prevented covering all the services. Individual agencies needed much help in selection of facts with news interest. We think we did well, however, considering we had less than one month to get together and form and execute plans. To carry out such a program in a community our size, at least six months and, even better, a year, should be allowed. It goes without saying that a good publicity committee should carry on a year-round comprehensive publicity program.

Now as to money. We had none. Posters, pamphlets, bulletins, letters, phone calls, mimeographing, supplies, pictures cost money.

Who should bear the cost? We put it up to the participating agencies at the first meeting. A number felt they were justified in contributing $50; others knew their agencies had nothing to contribute. The group voted that expenditures should be kept below $1,000. One display company estimated an exhibit such as we had in mind would cost at least $10,000. Our exhibit cost $385. A good fairy made up our deficit.

Department stores loaned costly supplies. One store sent $250 worth of new toys selected by a nursery school teacher. Others loaned new beds complete with blankets and sheets. They loaned beautiful mannequins. Medical supply stores loaned medical supplies and equipment. In fact we had to turn some down.

Was it worth while?

The arguments for:

All the public health agencies united in one common project for the first time and seemed glad to do it.

We learned from the public—the editors, business concerns, radio people, department stores—that people are eager to know more about health and most willing to help the nurses get their message across.

Thousands heard over the air the title "Public Health Nurse" mentioned in connection with her activities.

Thousands read about the school, industrial, state, city, and visiting nurse and saw her picture in uniform in the papers.

Thousands heard about the exhibit from the church pulpits.

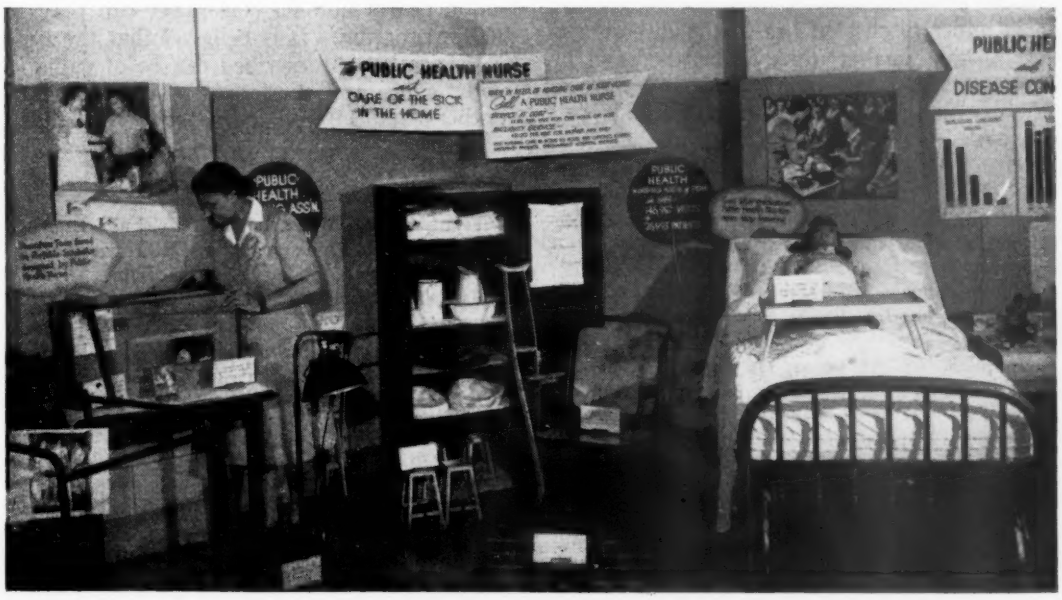
Recognition and prestige of the public health nurse were enhanced by public endorsement of the state governor, city mayor, county medical society, chamber of commerce, department stores, and the Buhl Planetarium.

237 Wassermann tests (2 positive)
978 x-rays were taken (3 positive)

The arguments against:

The attendance was disappointing, but considering that it was our first attempt, made on only one month's notice, and that our communities are widely dispersed, it was not too poor a showing. The exhibit was useful in serving as a center around which all our publicity revolved.

If an exhibit could be an annual event at which the public might anticipate seeing interesting examples of public health nursing and were given opportunities to receive some of the free health services, it might eventually be looked forward to and attract large crowds. It would seem that an exhibit might be most worth while at public occasions such as a fair where thousands are receptive to anything new and interesting.



The Public Health Nursing Association loan closet equipment

All in all, we do not feel too keenly about our mistakes and shortcomings, and of course, there were a number. In retrospect there is much we could have done differently and better. We certainly have learned that there is an almost unlimited opportunity to tell our story through receptive publicity channels if we have the time and help to avail ourselves of it.

The agencies which participated in and sponsored our exhibit were:

Pittsburgh Chamber of Commerce
Allegheny County Medical Society
Pennsylvania State Department of Health
Pittsburgh Department of Health
Independent School Districts
Pittsburgh Public Health Nursing Association
Cancer Prevention Clinic
Tuberculosis League
Pittsburgh Chapter, American Red Cross
Industrial Nurses Association
University of Pittsburgh Maternity Dispensary
University of Pittsburgh Public Health Nursing Department
Duquesne University Public Health Nursing Department
Pittsburgh Mother's Milk Registry
Pennsylvania State Nurses Association, District No. 6
General Health Council

Modernizing Maternity Practices

(Continued from page 329)

to know what an infant is like before she leaves the hospital. Efforts to cope with this aspect of the problem are being made in many hospitals. The so-called Rochester plan[8] seems the most important development in this direction.

The ultimate solution for the many problems under discussion lies in the direction of establishing smaller units for mother and infant. Already such units are in the process of construction and trial.[9]

SUMMARY

The experience of a municipal department of health in assisting local maternity hospitals in improving services both to mothers and newborn infants is described. The technics used and the problems encountered are discussed. Emphasis is placed on improvement in nursing technics and the part the public health nursing consultant can play in such a program. It is believed that the type of service herein described can be of value in modernizing and rendering safe the care of mothers and infants in maternity hospitals.

REFERENCES

[1]Gooch, Marjorie. "Ten Years of Progress in Reducing Maternal and Infant Mortality." *The Child*, November 1945, p. 77.

[2]Symposium on Streamlining Hospital Techniques. *American Journal of Public Health*, November 1945, p. 1196.

[3]Frant, S., and Abramson, H. "Epidemic Diarrhea of the Newborn." Chapter 28, p. 19 of Practice of Pediatrics by J. Brenneman. W. F. Prior Company, Maryland, 1945, Vol. 1.

[4]Rice, J. L., Best, W. H., Frant, S., and Abramson, H. "Epidemic Diarrhea of the Newborn." *Journal of the American Medical Association*, August 14, 1937, p. 475.

[5]Sanitary Code Section and Regulations Governing Lying-In Institutions and New-Born Nurseries. New York City Department of Health.

[6]Frant, S., and Abramson, H. "Epidemic Diarrhea of the Newborn: Epidemiology of Outbreaks of Highly Fatal Diarrhea among Newborn Babies in Hospital Nurseries," *American Journal of Public Health*, January 1938, p. 36.

[7]Watt, James. "Practical Implications of the Epidemiology of the Diarrheal Diseases of the Newborn." *American Journal of Public Health*, November 1945, p. 1205.

[8]Aldrich, C. Anderson. "The Significance of a Complete Preventive Medical Program for Children." *American Journal of Diseases of Children*, September 1944, p. 168.

[9]McLendon, P. A., and Parks, J. "Nurseries Designed for Modern Maternity." *Modern Hospital*, July 1945, p. 46.

Diet in Relation to Poliomyelitis

I. Foreword

By JESSIE WRIGHT, M.D.

IN THE STUDY of 400 cases of acute poliomyelitis in recent years, special histories bring to light the fact that most of the patients severely paralyzed had been taking a diet poorly balanced in nutritional elements and especially lacking in vitamin B complex and vitamin E. The combination of exhaustion and poor quality of diet was followed by severe prostration in patients who contracted this disease. After due consideration to nutrition during quarantine, an important part of convalescent care should include supervision of the diet by the family physician.

While each patient may have a variation of diet to meet the individual need as seen by the attending physician, it is helpful in patients who are being supervised in their homes to have the public health nurses know which foods are included in well balanced meals and which ones are acceptable sources of vitamin B complex and vitamin E.

The Public Health Nursing Association of Pittsburgh has provided the nurses who are visiting patients recovering from infantile paralysis with the following tables of foods, household measures, and content of thiamine, riboflavin, and niacin. A diet selected from these foods will contain essentials of the B complex and also vitamin E besides other nutritional factors.

McCormick of Toronto and others have made numerous reports of evidence suggesting that vitamin B complex increases resistance to certain diseases including poliomyelitis. Vitamin E is more effective in the presence of vitamin B complex. Anything that fortifies a patient against a disease or may lessen its severity is worth while. The public health nurses are in a strategic position to help physicians in educating patients or their families in the importance of a well balanced diet.

Dr. Jessie Wright is director, D. T. Watson School of Physical Therapy, University of Pittsburgh School of Medicine. Mrs. Leatham is nutritionist, Public Health Nursing Association, Pittsburgh.

II. A Diet High in Vitamins B and E

By Mrs. EVELYN LEATHAM

BASIC INFORMATION for planning an adequate diet high in B complex vitamins (thiamine, riboflavin, and niacin) should include daily requirements, sources of these vitamins, and amounts available in each. Foods to be included each day and suggested menus are helpful. Nurses of the Public Health Nursing Association of Pittsburgh who are visiting infantile paralysis patients have the following information at hand:

DAILY REQUIREMENT

	Thiamine-mg.[1]	Riboflavin-mg.[1]	Niacin-mg.[1]
Man (mod. active)	1.5	2.0	15
Woman (mod. active)	1.1	1.5	11
Children—1-12 yrs.	0.6-1.2	0.9-1.8	6-12
" Girls 13-15 yrs.	1.3	2.0	13
" Boys 13-15 yrs.	1.5	2.0	15

GOOD SOURCES OF B COMPLEX VITAMINS:

Food	Weight	Household Measure	Thiamine mcg.[2]	Riboflavin mcg.[2]	Niacin mg.[1]
Brewer's yeast	10 gms.	1 tbsp.	1630	370	5.0
Pork	100 gms.	1 average serving	1020	255	3.9
Ham, smoked	100 gms.	1 average serving	967	200	4.13
Liver, calves	100 gms.	1 average serving	520	3300	17.6
Liver, pork	100 gms.	1 average serving	500	2500	22.8
Beef, heart	100 gms.	1 average serving	500	880	7.6
Soybeans	30 gms.	½ cup cooked	450	225	1.3
Peas, fresh	100 gms.	½ cup cooked	400	200	1.76
Wheat germ	10 gms.	1 tbsp.	390	70	.34
Liver, beef	100 gms.	1 serving	380	3000	18.7
Wheatmeal	30 gms.	½ cup cooked	315	45	1.7
Kidney, beef	100 gms.	1 serving	270	1170	5.2
Oysters	100 gms.		225	220	1.3
Salmon, fresh	100 gms.	½ cup scant	210	140	7.4
Collards	100 gms.	½ cup cooked	200	250	.31
Ralston	100 gms.	¾ cup cooked	195	30	1.35
Kale	100 gms.	½ cup cooked	190	420	.5
Dandelion greens	100 gms.	½ cup cooked	185	225	—
Oatmeal	30 gms.	¾ cup cooked	174	42	.3
Cracked wheat	30 gms.	¾ cup cooked	165	44	2.01
Potatoes	100 gms.	1 small	160	40	.94
Cream of wheat	30 gms.	¾ cup cooked	158	48	.4
Navy beans			150	96	.85
Avocado	100 gms.	½ of pear	144	138	—
Green peas, canned	100 gms.	½ cup	120	60	.9
Sweet potatoes	100 gms.	1 small	110	70	1.08
Milk		1 glass, 8 oz.	108	432	.19
Herring, fresh	100 gms.		100	360	3.5
Mackerel	100 gms.		100	660	6.3
Codfish, fresh	100 gms.		90	120	2.3
Haddock			90	120	.9
Orange	100 gms.	1 small	80	30	.22
Bread, whole wheat	28 gms.	1 slice	78	36	.9
Bread, enriched	25 gms.	1 slice	60	37	.55
Peanut butter	150 gms.	1 tbsp.	57	48	2.81
Peanuts, roasted			57	48	2.7
Apple	100 gms.	1 small	40	30	.05
Salmon, canned	100 gms.	½ cup	30	140	6.0

[1] 1 gram is equivalent to 1000 mg. (milligram)
[2] 1 mg. is equivalent to 1000 mcg. (microgram)

Vitamin E is found in wheat germ, lettuce leaves, whole rice, water cress, egg yolk, meat, and milk.

DAILY DIET

In order to supply an adequate diet high in B complex vitamins, include the following foods in diet each day:

Milk—1 quart for children, 1 pint for adults

Eggs—1

Meat, poultry, or fish, or meat substitute—1 serving (Meats that are especially high in B complex vitamins are pork, liver, heart, or kidney. Serve liver once a week if possible. Meat substitutes are dried peas or beans, cheese or soybeans.)

Whole grain cereals—1 serving (uncooked cereals—Rolled Oats, Wheatena, Wheatsworth, Wheatmeal, New Enriched Cream of Wheat, Maltex, Malto-meal; Prepared cereals—Wheaties, Shredded Wheat, Ralston Bits, Puffed Wheat, Cheerioats.)

Whole wheat bread at every meal

Vegetables:

Potato—1 serving

Green leafy or yellow vegetables—2 servings (For example, spinach, kale, collards, Swiss chard, turnip tops, beet tops, green beans, green peas, broccoli, carrots, squash, sweet potatoes.)

Another vegetable—1 serving (For example, beets, cauliflower, parsnips, corn, turnips, lima beans —one of these vegetables should be raw.)

Fruit:

Citrus fruit—1 serving (Oranges or grapefruit or any vitamin C rich fruit or vegetable—tomatoes, raw cabbage, raw green leafy vegetable such as spinach.)

Another fruit—1 serving (Apples, peaches, pears, cherries, plums, bananas, prunes, et cetera.)

Fats:

Butter or oleomargarine

Use 2 tbsp. peanut butter on bread

Wheat germ—1 tbsp. sprinkled on cereal (Wheat germ is also an excellent source of vitamin E.)

Other foods:

Once a patient has eaten all the above foods, then allow him to eat such desserts as puddings, cookies, et cetera.

Since soybeans and wheat germ are so high in B complex, incorporate them in cookies, muffins, by substituting them for some of flour called for in recipe.

Vitamin supplements as ordered by the doctor can be mixed with peanut butter and spread on bread or mixed in milk.

Menu Guide

Use above foods in three meals a day as follows:

Breakfast	*Lunch*	*Dinner*
Citrus fruit	One substantial dish—	Potato
Whole grain cereal	eggs, casserole dish, soup and	Meat or meat substitute
Milk	sandwich	Green leafy or yellow vegetable
Toast	Vegetable—green leafy or other	Raw vegetable
Butter or oleomargarine	vegetable	Bread
Beverage	Bread	Butter or oleomargarine
	Butter or oleomargarine	Fruit or other dessert
	Dessert—fruit or other dessert	Milk
	Milk	

Mid-morning and mid-afternoon—Milk drink

Sample Menu

Breakfast	*Lunch*	*Dinner*
Orange	Poached egg on toast	Baked potato
Rolled Oats (with wheat germ)	Spinach	Pot roast of beef
Milk	Canned peaches	Carrots
Toast	Milk	Cole slaw
Peanut Butter		Gingerbread
		Milk

Mid-afternoon Lunch—Peanut butter and bread

ANALYSIS OF DIET

Food	Weight (gms.)	Household Measure	Thiamine mcg.	Riboflavin mcg.	Niacin mg.
Milk		1 quart	439	1755	.78
Bread, enriched	100 gms.	4 slices	240	148	2.20
Cereal—rolled oats	30 gms.	⅔ cup, cooked	174	42	.30
Egg		1	75	175	.03
Meat—(beef, lean)	100 gms.	1 average serving	192	276	8.6
Vegetables					
Potatoes	100 gms.	1 small	160	40	.94
Green leafy vegetables					
Spinach	100 gms.	½ cup, cooked	125	300	.72
Carrots	100 gms.	½ cup, cooked	100	70	1.47
Another Vegetable					
Cole Slaw	50 gms.	¾ cup, grated	50	25	.15
Fruit					
Orange	150 gms.	1 medium	120	45	.33
Peaches	100 gms.	2 halves	20	20	.13
Butter or oleomargarine					
Wheat germ		1 tbsp.	390	70	.34
Peanut Butter		2 tbsp.	114	96	5.6
		TOTAL	2,199	3,062	21.59
If Brewer's Yeast, dried, is used in addition or other vitamin supplement (as ordered by physician)	10 gms.	1 tbsp.	1630	370	5.0
		TOTAL	3,829	3,432	26.59

More About the Convention

TWELVE THOUSAND professional nurses of the NOPHN, NLNE, and ANA are expected to attend the Biennial Convention in Atlantic City, N. J., September 23-27. Plans at headquarters for this first large convention since Pearl Harbor are culminating in a sure-fire program. Individual plans for attendance at the Convention are also shaping up, and all who have not made train and hotel reservations are urged to do so *soon!* Last minute facts as we go to press are:

Arrangements have been made for two NOPHN membership meetings at the Biennial Convention. One, scheduled for Tuesday, September 24, 4:15 to 5:15 p.m., will be a business meeting for state membership representatives. Wednesday evening, 6 to 8 p.m., is the time set for the NOPHN membership supper and rally. Details of the program and arrangements for advance reservations for the rally will be published in the August magazine. Watch for this special announcement and the reservation blank accompanying it.

Conventionites interested in tourist accommodations will be glad to learn that there are a number of tourist camps or motor courts within 8 to 10 miles of Convention Headquarters in Atlantic City. Full particulars can be obtained from A. H. Skean, Convention Bureau, 16 Central Pier, Atlantic City, N. J. Typical rental charges, if accommodations are secured through the Convention Bureau, are: $5 and $6 per night for 2 persons for double and twin beds, respectively, including maid service and bath; $3 to $6 per couple and $6 to $8 for 4 persons, all double beds, all rooms with bath. Applicants should specify number in their party and indicate inclusive dates accommodations will be required.

The tentative biennial program will be published in the August issue of the magazine.

Reminder is made again of the urgency for sending hotel reservations in early. To facilitate matters, use the hotel application form carried in the April magazine, page 202.

Job Classification and Salary Study

By MRS. BENJAMIN W. THORON

IN MAY 1944, the Community Chest of the District of Columbia and the Council of Social Agencies decided to make a study of the inequities among personnel having similar responsibilities and duties in the 57 member agencies. The aim was to gather facts and then to establish measuring rods for jobs and salaries.

GENERAL PLAN

A Joint Committee representing the Council's Board of Directors, the Chest Budget Committee, the Executive Conference (agency executives), the Chest and Council staffs, the U. S. Civil Service Commission, and the community-at-large was appointed. The Comtee's first step was to distribute to all employees a questionnaire modeled after civil service and industrial forms. Each employee was asked to give a detailed description of his duties and responsibilities. Executives were asked to give information about each position in their agency, and to list the minimum qualifications needed to fill it. Finally the executives and presidents of the boards were requested to make such corrections or additions to the employee statements as they thought necessary.

After seven months, about two thirds of the questionnaires were back in the Committee's hands, an undigested mass of information. There was evident uneasiness among the agencies over the whole undertaking. At this point, the Joint Committee decided to consult with agency personnel at all levels by means of discussion groups and to engage a professional personnel technician to analyze the material and to establish job classifications and to write specifications for each.

Working subcommittees of the Joint Committee were set up for the usual six functional fields: casework, recreation and group work, health and nursing, institutional maintenance, administrative, and clerical. As part of the process of establishing job specifications, these subcommittees, working with the personnel technician, were given the responsibility for holding discussion meetings with agency staff members in each field. Each of the subcommittees followed the general plan of analyzing job material and then submitting it for group study and discussion. The subcommittees usually had a professional worker for chairman, several lay and professional members, and a Chest or Council staff member. They worked with the personnel technician who was experienced in social and health work. Information about education and experience required for comparable positions was secured from other Community Chests and Councils, and from national and local agencies, both public and private.

Once a series of job specifications had been set up to the satisfaction of a subcommittee, the plan was taken to the various agencies for interpretation and suggestions from board and staff.

After final review and revision by the subcommittee, the "position classifications" were submitted to the Joint Committee. This rather lengthy process of group tests and contributions helped to insure validity of the plan and its acceptance.

In establishing the pay scales for each field of work, the above procedure was again followed. When it came to the task of allocating each employee to his proper place in the salary scale, the Joint Committee recommended that the appropriate division secretary of the Council and the personnel technician confer with executives of each agency on the placement of the individual employee. The final report of the Joint Committee went to the Budget Committee of the Community Chest for ap-

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proval and from there to the Executive Committee and to the Board of Trustees of the Chest. The final report includes not only the job specification and salary study, but a recommendation for a permanent Committee on Classification and Salaries to report to the Executive Committee of the Community Chest.

The whole process of this study took about a year from the time of inception to the time it was put into effect. Pay raises were retroactive to the first of the year 1945.

IVNS BOARD PARTICIPATION

When the director of the Instructive Visiting Nurse Society reported to the IVNS Nursing Committee that the specifications for the classification of public health nurses and supervisors, which came under the Health and Nursing Subcommittee of the Joint Committee, of which she was chairman, were practically completed, and that they were about to consider salary scales, the Nursing Committee felt that someone from the Society's Board of Directors should also study this question. It was decided that the chairman of the Nursing Committee be asked to study the specifications with the director and make suggestions as to salary scales. The suggestion was also made that the chairman of the Nursing Committee interpret the Job Classification and Salary Study to the Board.

The chairman of the Nursing Committee participated in all further conferences held between the director and the professional technician, and the health secretary of the Council of Social Agencies when final specifications and salaries were arranged.

Prior to the Job Classification and Salary Study, the IVNS had only three different salaries for staff nurses with a given number of positions in each salary group, allotted by the Budget Committee of the Chest. Promotion was based on length of service, ability, and vacancies. There were three different salaries paid to supervisors. These differences were made because the IVNS had asked for raises for the individuals. Naturally under this system there were inequities. One of the difficulties that the IVNS had in the past in procuring nurses was the fact that the health department salaries and opportunities for promotions were a great deal better than ours. Consideration was given to the Civil Service setup, and, though their scale was not followed exactly, the final classification followed their general plan.

THE NEW NURSING CLASSIFICATION

In the Classification as it now stands, we have Public Health Nurse I with four steps, with annual increments of $60. For this grade, we have the minimum educational requirements of high school and graduation from an accredited school of nursing.

Public Health Nurse II also comprises four steps with annual increments of $60, requiring one year of full-time paid experience in a public health nursing agency and one quarter (at least 15 semester credits) in public health nursing in a university program, or completion of a year's study in public health nursing, including field work in a university program, or the equivalent in a combination of education and experience.

Public Health Nurse III has five steps with annual increments of $100, requiring completion of a year's study in public health nursing in a university program, and two years of full-time paid experience in a public health nursing agency, or the equivalent in a combination of education and experience.

In detail, the qualifications for Public Health Nurse I, II, III are:

Public Health Nurse I

1. a. Graduation from an accredited high school or its educational equivalent which meets college entrance requirements.

b. Graduation from an accredited school of nursing requiring a residence of 2½ to 3 years in a hospital having a daily average of 100 patients, with the necessary affiliations for a thorough practical and theoretical training, including medical, surgical, obstetric, pediatric, orthopedic, communicable disease and psychiatric nursing.

c. Evidence of registration in the District of Columbia.

2. Knowledge of basic nursing principles and methods, physical and mental illnesses; some knowledge of individual and community health problems, individual and group behavior, and nutrition.

3. Some ability to establish and maintain successful professional and working relationships; some ability to meet and instruct the public; tact; adaptability; discernment in evaluating situations and making decisions; good health.

Public Health Nurse II

1. a, b, and c the same as for Public Health Nurse I

d. 1 year of full-time paid experience in a public health nursing agency under direct qualified supervision and 1 quarter (at least 15 semester credits) in public health nursing in a university program approved by the National Organization for Public Health Nursing

or

Completion of a year's study in public health nursing including field work in a university program approved by the National Organization for Public Health Nursing

or

The equivalent in a combination of education and experience

2. Knowledge of basic and public health nursing principles and methods, physical and mental illnesses, individual and community health problems, individual and group behavior, nutrition, community medical and social resources.

3. Ability to establish and maintain successful professional and working relationships; ability to meet and instruct the public; tact; adaptability; discernment in evaluating situations and making decisions; good health.

Public Health Nurse III

1. a, b, and c the same as for Public Health Nurse I and II

d. Completion of a year's study in public health nursing in a university program approved by the National Organization for Public Health Nursing, and 2 years of full-time paid experience in a public health nursing agency under direct qualified supervision *or* the equivalent in a combination of education and experience.

2. Thorough knowledge of basic and public health nursing principles and methods, physical and mental illnesses, individual and community health problems, individual and group behavior, nutrition, community medical and social resources.

3. Marked ability to establish and maintain successful professional and working relationships; marked ability to meet and instruct the public; tact; adaptability; discernment in evaluating situations and making decisions; good health

Public Health Nurse Supervisor has five grades with annual increments of $100.

Educational Directors fall into five grades with annual increments of $100.

The administrative salaries were not set up by the Health and Nursing Subcommittee but were sent straight from the Chest to the Board of Directors of the IVNS. The same was true of the clerical salaries.

Provision was made long tenure.

EXTRA PAY FOR LONG SERVICE

1. *Ten Years' Service*

Employees with a minimum of 10 years of meritorious service in 1945, who have reached the highest pay applicable to the present position, upon the recommendation of the Board of the agency, shall be eligible to receive a salary increase equal to 10 percent of the maximum salary for the position. This salary increase shall be made effective in 1946.

In explanation of above, the qualifying employee may have had 15 years in service or more and receive only the first long-service increment of 10 percent in 1946. Also a person may have been with the agency more than 10 years and not be at the top of the range for the position held. This person would not be eligible for the long service 10 percent increase in 1946.

2. *Fifteen Years' Service*

Employees with a minimum of 15 years of meritorious service in 1946, who have reached the highest pay applicable to that position, upon the recommendation of the Board of the agency, shall be eligible for another increase in salary equal to 5 percent of the maximum salary for that position. This salary increase shall become effective in 1947. Normally there shall be a 5-year interval between the extra pay for the 10-year tenure and the 15-year tenure. It shall not be necessary for the employee to be in the same position for 15 years or more but the individual must have reached the top of the range of the position held in the same agency to be eligible for any of the long-service increases. The person who has 15 years of service in 1945 and is at the top of the range will be eligible to receive the 10 percent increase in 1946 and another 5 percent increase in 1947.

3. *Twenty Years' Service*

Employees with a minimum of 20 years of meritorious service in 1947, who have reached the highest pay applicable to that position, upon the recommendation of the Board of the Agency, shall be eligible for another increase in salary equal to 5 percent of the maximum salary for the position. This salary increase shall become effective in 1948. Normally there shall be a 5-year interval between the extra pay for 15-year tenure and the 20-year tenure.

An employee who has 20 years of service in

an agency becomes eligible for a 10 percent increase in 1946, another 5 percent in 1947, and the final increase of 5 percent in 1948, and is not required to have held the same position for any definite length of time.

SUBSTITUTING THE NEW PLAN

Before the final settlement, the chairman of the Nursing Committee reported back to her Committee the progress that had been made in the conferences and showed on a blackboard the old salaries as compared to the proposed classification and salary scale. The suggestions of the Committee were incorporated to go back to the Health and Nursing Subcommittee. The professional technician encouraged the participation of the Nursing Committee chairman in the conferences and indicated that she wished other boards would follow the IVNS in this respect. She felt it would make for better feeling and understanding, not only among the board members, but also among the staff.

The chairman of the Nursing Committee also conferred with the director, the professional technician, and the health secretary of the Council on placement of each employee. In addition to the aforementioned conferences, a great deal of hard work and time were spent on this very difficult problem by the director with the assistant and educational directors, and the Nursing Committee chairman. The placement of the nurses who had been with the organization for a long time and who were receiving the highest staff nurse salary, but who could not meet the new educational requirements, was the most difficult problem. These particular cases were brought to the Nursing Committee for final settlement. It was felt that, under the circumstances, long and faithful service outweigh the educational requirements and they were put in Public Health Nurse III.

All the facts and figures on the Job Classification and Salary Study as approved by the Nursing Committee were presented to the Board of Directors of the IVNS by the Nursing Committee chairman. The ensuing questions were answered by her and the director.

Due to our very close contact with the Job Classification and Salary Study, very little difficulty was experienced in gaining the complete sympathy of the Board and staff with this very important community project. Though there are still a few minor complaints, these are now on the way to being settled by the Committee on Classification in the Community Chest.

Structure Study Field Trips

IN THE furtherance of the structure study of the six national professional nursing organizations currently underway by Raymond Rich Associates, analyses of the problems and programs on the local level are being made. In this connection, field trips to various parts of the country are being undertaken this summer by members of the study staff.

Elina Orr had the following schedule: Cincinnati, Columbus, and Cleveland, Ohio—1st week of June; San Francisco and Los Angeles, California—June 18 to 25; El Paso—June 26; Dallas and Fort Worth, Texas—June 27; Birmingham, Alabama—June 28 to 29. Dr. Neva Deardorff visited Chicago, Illinois the week of June 25 and will be in Colorado early in July. Mr. Rich himself plans to visit between now and the end of July: Philadelphia, Baltimore, Washington, D.C., Providence, Boston, Detroit, Ann Arbor, Lansing, Chicago, and possibly Minneapolis.

William Cherin, who recently set up a large research staff in the U. S. Department of Justice, is a new member of the Raymond Rich Associates study group who will work with Mr. Rich in the final analysis of all records, reports, and literature pertaining to the study.

Individual contributions toward the total cost of the survey are coming in, but the amount received to date is still short of the sum needed to defray all the expenses which will be incurred. The appeal is renewed to all nurses to assist in this vital undertaking which will affect the future of the profession and its members. Plans have been made to present the final report of the study at the Biennial Convention.

Community Planning for Nursing Service*

THE CITIZENS of any community are responsible for health services just as they are responsible for the schools, fire, and police protection. Their stake in all these is high. If services are adequate and satisfactory, people of the community benefit. If services are poorly organized and inefficient, the people suffer. It is up to citizens to get what they pay for and to pay for what they want.

But citizens need technical advice in determining whether their community services are adequate and well organized and they turn to representatives of the different professions for this advice. This is particularly true of nursing services, which have a unique contribution to make toward better living for everybody. The nursing profession is responsible for providing technical advice and setting professional standards.

Now is a strategic time for citizens and nurses to develop ways of working together to provide the best kind of nursing service for the future. More people than ever before are interested in nursing. Nurses as a professional group cannot plan alone for the community because too many factors are entirely beyond their control. Any professional group, if it wants social action, must seek the cooperation of the community. In the long run it is the people who decide how much and what kind of nursing they want and will pay for. It is therefore urgent for nurses to learn how much and what kinds of nursing care the community needs and wants, and for the community to learn something about the professional problems involved. Only through joint action can problems be solved and real progress take place.

Citizens also need to know the answers to many questions vital to the health of their families and community. Is the program of nursing education really preparing nurses to do the job needed in the community? Is nursing attracting the right type of women? Is administration of organized nursing services efficient and economical? Is adequate service available to convalescents and people with long-term sickness? Are families of high and low economic levels equally able to get nursing care when they need it?

Nurses need to know public attitudes about nursing and social and economic factors which must be considered in providing nursing care.

Although their functions are different, the ultimate goal of citizens and the nursing profession is identical—to make available the best possible nursing service. Neither group working alone can solve the problems. The goal—vital to the well being of the people—deserves the best that the community and the profession have to give.

To provide for cooperative action and planning between citizens and nurses, some kind of community machinery is necessary, with officers, executive committee, or board of directors, and working committees to permit study and action as needed. This machinery can best be provided by an organized community group. In some areas it takes the form of a nursing committee or section in the health division of the Council of Social Agencies, and in other areas it is known as a council on community nursing.

This organization can be a forum where representative citizens, users of nursing service, and nurses can discuss ways of improving nursing service and develop a mutual understanding of the close relationship between professional standards and quality of nursing service. It can also serve as a clearing house for all plans in the community that affect nursing. All strictly professional matters should be properly referred to the professional nursing organizations, but other community agencies and institutions should be informed of any action taken by them, and professional organizations in turn,

*Prepared by the Joint Committee on Community Nursing Service of the American Nurses' Association, the National Organization for Public Health Nursing, and the National League of Nursing Education.

informed of any plans made by the other agencies. Projects which do not fall exclusively within the scope of the individual member agencies and are of interest to more than one agency may be carried by the council.

To help communities organize such a group, the Joint Committee on Community Nursing Service of the American Nurses' Association, the National Organization for Public Health Nursing, and National League of Nursing Education has prepared the following suggestions. These are intended to be a guide and must, of course, be adapted to fit local conditions. The Joint Committee will be glad to give communities further help if it is needed.

A GUIDE TO ORGANIZING A COMMUNITY GROUP INTERESTED IN NURSING SERVICES: SOME PRINCIPLES

I. *Keep the machinery simple.* The principles embodied in the sample bylaws may be applied in many ways. Each community should develop the plan that best fits its needs.

II. *Cover the natural geographic area.* The smaller the area covered, the more similar are the interests. If the area is the same as other community planning groups, joint planning and cooperation are simplified. If the area covered by the professional and the community organizations is not the same, the president would not always be able to represent the organization. In such cases the professional organization might appoint as its representative one of its members within the area of the community organization.

III. *Follow the method of organization that promises the best for the community.* The initiative in getting the organization started may come from any group interested in nursing service. However, nurses usually make the first move. The steps in organization are simple.

1. A steering committee may be appointed in any of the professional nursing organizations or other appropriate groups. The purpose of this committee would be to explore the need for a community planning organization and what it might accomplish.

2. A larger meeting with wide representation may then be called to discuss the report of the steering committee.

3. If this group decides a permanent community organization is desirable, committees would be appointed at this time to draw up the bylaws and to nominate temporary officers.

4. After bylaws are approved, officers and board members may be elected. Future planning would then be their responsibility.

IV. *Choose a descriptive name.* As the contemplated organization is a community rather than a professional one, this fact should be indicated in the name. Several different types of community organizations are at present interested in nursing services. Some are called councils on community nursing, others nursing committees, or nursing sections of a health council or health division. The name and the organization pattern are dependent upon the structure and desires of the community served.

V. *Provide for agency members.* Agency members include all institutions and agencies giving nursing service, professional and community organizations. The following agencies might be included:

Nursing Service Agencies

The inclusion of the administrators of nursing service agencies whose programs may be affected and who can contribute from day-by-day operation in the field, is essential. A member of the board of directors, the policy making body of these agencies, is the other kind of representation necessary.

Professional Organizations

If the professional nursing organizations have sections, each of these should be represented. Allied professional organizations such as the medical society should also have representation.

Educational Groups

In addition to schools of nursing the

board of education and local colleges would be included in this group.

Allied Community Organizations

Civic and service organizations would come in this classification. Groups included vary considerably in different communities. It is often preferable to begin with a limited number of members. Later as the need for wider representation is felt, the number can be increased.

VI. *Provide for individual members.* Certain interested citizens, both nurses and nonnurses who have a valuable contribution to make, may be chosen as individual members. The number of participants can be still further increased by appointing other individuals as members of special and standing committees. These members might well be people outside of the regular membership of the participating groups mentioned above.

VII. *Plan for technical advice from the nursing profession.* There needs to be mutual understanding that the professional organization is responsible for setting professional standards and for safeguarding the welfare of its members, while the community organization is concerned only with nursing services. When this is the case each group implements and stimulates the other. Two-way referring of problems and reporting on action taken furthers this understanding.

VIII. *Establish a clear-cut and specific relationship with other community planning groups.* Nursing is not an entity that stands by itself in the community. It affects and is affected by every other service in the community. For this reason it is suggested that the group interested in nursing service become a member of the council of social agencies, county planning committee, or other overall planning body. This can be accomplished by direct membership or indirectly by membership in the health division of the larger body. Most organizations having direct membership are called nursing councils, while those having membership through the health division or health council are usually called nursing committees or sections.

There are advantages, however, in the new group becoming familiar with its own unique purpose, program, strength, and value before being too closely affiliated with a larger group. This process of developing group identity might possibly require a year. It is possible to avoid a policy of isolation during this period by asking for representation on other appropriate committees within the community. It would be advisable, also, to consult frequently the planning group with which an affiliation is contemplated, in order that mutually satisfactory arrangements may be developed.

If there is no larger community planning group such as a council of social agencies, a group interested in nursing service may stimulate the formation of such a planning body. If citizens accept responsibility for nursing services, it leads the way for their accepting responsibility for other services.

IX. *State the purpose broadly.* It is important to maintain practical limitations to the field of interest, yet the statement of purpose should be broad enough not to hamper the activities of the group. The purpose as stated in the bylaws, although in general terms, should be thoughtfully criticized and adapted to the local situation.

X. *Make the board the heart of the council.* Even in a small community the membership body with broad participation will be too unwieldy for detailed consideration of special projects, committee reports, and the specific program of the organization. The board of directors, therefore, should be the central planning body through which all activities of the group clear. The attached bylaws indicate one way of selecting the board of directors.

Most nursing councils already in existence have had a very meager budget until they proved themselves of sufficient value to warrant support from the community chest. Even with a budget that does not permit full-time personnel, an organization may have a worth-while program by considering the board of directors the planning group and the appointed committees the working groups. These committees will accomplish more if they have specific functions and definite dates to report to the board of directors.

XI. *Start with whatever financial help is available and plan for what is ultimately desired.* The community chest is the usual source of funds. These funds are available only to community groups that have demonstrated that their program is of benefit to

the community. During the year when the community nursing service group is getting organized there are several possibilities for financing its operation. One is to share a professional secretary with one or more of the professional organizations In some communities the program has been financed by funds from hospital associations, individual gifts, foundation support for special projects, scholarships from civic clubs, donations of publicity from manufacturing firms. All sources of financial support used by nursing councils for war service are possibilities for the community organization for nursing services. In some instances a nursing organization has underwritten part of the initial expenses of such a community organization. Where this is done it should be made clear that the nursing profession is making a contribution to the community and not assuming a responsibility which belongs to the community as a whole. The following items should be included in the budget or provided by arrangements with another community or professional organization.

Office rent
Office maintenance
Office equipment
Office expense, including telephone, postage, and stationery
Salary of professional secretary
Salary of stenographic secretary

A business man or banker would be a very helpful member of the committee on finance.

XII. *Decide on projects most urgent for the health of the community.* The local situation will, of course, determine the program. Some of the problems will be unique to the particular community, while other problems will be common to communities all over the United States. An initial project might well be publication of a list of all agencies and institutions and a description of the nursing services they offer. Such a project has the advantage of being tangible, simple, and educational. If a more complete picture of the community and its nursing services is desired the Schedule for a Survey of Community Nursing Service may be used.* Committees can be appointed to work on each of the seven sections of the schedule.

*This form is available from the National Organization for Public Health Nursing, 1790 Broadway, New York 19, N. Y. $1 per copy.

Three problems at present are most frequently found in local communities. These are listed here together with suggestions of how concerted action may help in their solution.

Problem 1. *Shortage of nurses*

The board of directors of the community group interested in nursing service might appoint a committee to determine the extent of the problem. This committee would then report its findings back to the board of directors. Possibly the report would indicate that the number of nurses in hospitals and public health agencies is insufficient to give adequate service and that nurses are leaving for positions with better salaries.

As a next step the committee would need to learn from the district nurses' association what are the professional standards for personnel policies and standards. These would be studied by the committee with interpretation available if necessary from nurse members of the committee. Recommended action might include any or all of the following:

Publicize the professional standards and the fact that they are supported by the community groups.

Request a conference with representatives of the hospital association or public health agency to determine how the group may help remedy the situation.

Survey the nurses released from military service. If they are not returning to nursing, learn why. If feasible, formulate and sponsor a community plan, in which all agencies participate, to meet the situation.

Determine number and type of nonprofessional workers available. Develop and promote, with proper community agencies, the best plan to meet local needs.

Study the standards for civil service positions. If the professional nursing classifications, specifications, examinations, and salary schedules were not established in accordance with professional standards ask for a conference to interpret the need for this. Follow through to make sure that service is safeguarded by the use of professional standards for nursing positions in civil service.

Problem 2. *Enrollment of student nurses.*

A special committee would be appointed by the board of directors.* It is advisable that members of the committee include representatives from the General Federation of Women's Clubs and the American Legion Auxiliary as they have demonstrated their interest in this problem; a public relations expert; representatives of the schools; and the superintendent

of education. The committee's initial task would be to learn facts and suggest plans for approval by the board of directors. The following might be included in the plans of the committee:

Obtain and publish list of schools with necessary information—daily average number of patients, number of beds, cost, educational affiliations, reciprocity available to graduates, living arrangements, college credit, dates classes enter

Set up a speakers' bureau to present material to parent and student groups. (Student nurses make an excellent contribution here.)

Call meeting of high school principals and counselors to present opportunities in nursing and give them basic information essential for counseling students about nursing

Assemble all material regarding nursing as a career and material on local situation in a packet to be sent to each school

Interest local manufacturing or business firms in sponsoring essay and poster contest on careers in nursing

Obtain publicity—radio, newspaper, et cetera, free or paid, by local manufacturing or business firms

Publicize openings available to graduates of local school. Run series of articles on choices for careers in nursing

Plan open house in all schools of nursing on same day and invite college and senior high school girls

Investigate need for financial assistance to student nurses. It is advisable that members of the committee include representatives from the General Federation of Women's Clubs and the American Legion Auxiliary, a public relations expert representative of schools

Publicize available facilities for counseling students interested in nursing

A student nurse enrollment program is more effective if there is community understanding of the fact that the hospital's purpose is to give service to the sick, while a school of nursing is an educational institution. During a program to enroll student nurses the entire community should give thought to such questions as the following:

Does a girl choosing a career in nursing have a reasonable chance for a satisfying personal life, opportunity to contribute as a community citizen?

Will the community have available five and ten years from now the quantity and quality of service it desires if judged by the students enrolling now?

Is the school in which students are being enrolled educationally sound or is it meeting service needs that should be met in other ways?

Are women being asked to spend years of preparation for a career and later will they be expected to spend a large percent of time doing non-professional tasks and earning little more than a person who spends a few weeks in preparation?

Problem 3. *Need for bedside nursing care in the home for entire community*

Here again a special committee would be appointed by the board of directors, probably in this instance because of the referral from some community groups. The problem presented might be the inadequate nursing service existing for some group such as the chronic convalescent or upper middle income level families. The first step would be to call a meeting with representatives of agencies giving nursing care in the home to learn the problems involved. The committee would then find out what has been done to solve the problem in other areas and would consult the professional organization. Frequent meetings with representatives of the agencies to consider a plan of action would then follow. Some of the possibilities for action are:

Include home nursing care in hospital and medical insurance plans

Plan for closer correlation of hospital and home nursing care by establishing public agency substations in hospitals

Pool nursing personnel of all agencies giving service in the home in order that one nurse may give complete service in one family

Increase staff for agency giving bedside care

Determine method by which patient will pay tax-supported agency for bedside service

Arrange for practical nurses to give care in the home. Supervision of the practical nurse and health supervision of the family would then be the responsibility of the public health nurse.

Provide housekeeper service

*Material is available to this committee from the Committee on Careers in Nursing of the National Nursing Council, 1790 Broadway, New York 19, N.Y.

Note: This article is also published in the *American Journal of Nursing* for July 1946, but without the bylaws which follow.

SUGGESTED BYLAWS
COUNCIL OR COMMITTEE ON COMMUNITY NURSING

ARTICLE I.—*Name*

The name of this organization shall be .....

ARTICLE II.—*Purpose*

The purpose of the ..... shall be to promote such measures as will meet the nursing needs of the community. To this end it shall:

Study nursing in relation to total community needs

Study factors that affect the adequacy of the service available

Provide a forum for the producer and consumer to promote mutual understanding and joint action

Encourage and give support to measures that will improve nursing service in the community

Serve as a clearing house on all matters pertaining to nursing in the community

Carry programs which are of interest to more than one group, but do not fall within the responsibilities of any agency

ARTICLE III.—*Membership*

The membership of this organization shall consist of two kinds, as follows:

1. *Agency.* Those institutions and agencies providing nursing service in the community and those organizations concerned with nursing shall be eligible. Recommendation to membership shall be made by the Committee on Membership subject to the approval of the Board of Directors. Agency or organization representation may be by the President of the Board, the Executive and/or someone appointed by the agency or organization.

2. *Individual.* Those individuals who are or may become interested in nursing. Recommendations to such membership shall be made by the Committee on Membership to the Board of Directors for approval.

ARTICLE IV.—*Officers*

The officers of the council shall be a President, Vice-President, Secretary and Treasurer, who shall perform the duties that are implied in their respective titles. Officers shall be elected for one year or until their successors are elected. No officer shall serve more than three successive elected terms.

The President shall be an ex-officio member of all committees.

ARTICLE V.—*Board of Directors*

The Board of Directors shall be composed of the elected officers, who shall also serve as officers of the Board, the chairman of committees, and the presidents of the (district or local) nurses association, league of nursing education, and organization for public health nursing and three or more other directors elected by and from the membership.

The directors-at-large shall be elected for terms of three years each, but of the three elected the first year one shall be elected for a one-year term, one for a two-year term, and one for a three-year term so that each year thereafter one vacancy shall occur.

The Board of Directors shall conduct the business of the council under the general direction of the council membership.

ARTICLE VI.—*Committees*

The Board of Directors may create special committees at any time and delegate to the committees such duties and powers as it deems advisable.

Standing Committees

1. Executive Committee. The officers of the Council and two elected members of the Board of Directors appointed by the President shall compose the Executive Committee. This Committee shall act between meetings of the Board, on emergency matters and take over any business delegated to it by the Board of Directors.

2. Committee on Finance. This Committee shall prepare a budget to be submitted to the Board of Directors and other usual duties. The Treasurer shall be a member of this Committee.

3. Committee on Nominations and Membership. The Committee on Nominations and Membership shall prepare a ballot nominating officers and members of the Board of Directors for the ensuing year. The people nominated shall have consented to serve if nominated and at least one name shall be presented for each office to be filled.

4. Committee on Programs. This Committee shall perform the duties implied in the title.

5. Committee on Revisions and Bylaws.

6. Other committees as the local situation demands such as public information, legislation, et cetera.

ARTICLE VII.—*Meetings*

At least four meetings, including the annual meeting of the Council, shall be held each year at the time and place decided upon by the Board of Directors.

The Board of Directors will meet each month except July and August at a time and place decided upon by the Board.

The Executive Committee will meet upon call of the President or any two of the elected officers between regular meetings of the Board to consider any urgent business.

ARTICLE VIII.—*Quorum*

Ten percent of the membership shall constitute a quorum at any annual or regular meeting.

Five members of the Board of Directors shall constitute a quorum at any meeting of the Board of Directors.

Three members of the Executive Committee shall constitute a quorum at any meeting of the Executive Committee.

ARTICLE IX.—*Elections*

The voting body shall consist of all the members of the Council.

Each year a President, Vice-President, Secretary, Treasurer and one of the directors shall be elected by a plurality vote to serve for one year or until their successors are elected.

The Board of Directors may appoint a person to fill a vacancy for an unexpired term of any officer.

Voting may be done by mail; in such case a ballot shall be sent to each member of the organization at least three weeks before the date of the annual meeting with the instructions that such ballots must be returned before the day of the annual meeting.

ARTICLE X.—*Order of Business*

The order of business at any meeting of the Board of Directors or those of the council shall follow those of usual parliamentary procedure.

ARTICLE XI.—*Fiscal Year*

The fiscal year shall be the calendar year.

ARTICLE XII.—*Amendments*

Bylaws of this organization may be adopted or amended by a two-thirds vote of those present and voting at any meeting, notice of said amendments having been included in the notice of the meeting, or by a unanimous vote, of those present, without notice.

ARTICLE XIII.—*Parliamentary Authority*

The rules of parliamentary procedure, comprised in Roberts Rules of Order, shall be the authority of all meetings of the organization subject to special rules which may at any time be adopted.

A nursing committee which is a part of a health council, or council of social agencies, does not usually have bylaws. Rules of procedure are used in such a case. These include a statement of policy and objectives, officers, time of meeting, and methods of operating.

Thumbsucking

By BARBARA McWILLIAM, R.N.

THUMBSUCKING is only one of the many problems which cause distress to the parents when it occurs in their offspring. As a public health nurse, the thought has often occurred to me that all of us as nurses should learn to analyze, as well as help to interpret to the parents or the family, some of those problems which may be traced to emotional difficulties in many cases. There must be adequate recognition by the nurse that these are real difficulties, not only to the child but to the parents.

While breast-fed babies may and often do suck their thumbs, it occurs frequently in bottle-fed infants. Perhaps Johnny has been brought up strictly on schedule by his overanxious parents. At the end of the prescribed feeding period, his bottle is rather forcefully pulled from his mouth. He does not get a chance to "enjoy his meal," as his own parents do. Again his busy mother may have propped the bottle of milk against the pillow, instead of taking time out to hold him in her arms as she did his brother "Bill." Johnny instinctively misses that extra affection that his brother "Bill" received, for "Bill" nestled in the arms of his mother, nuzzling close to her warm, comforting breast, when he was fed.

Some infants suck on a rubber nipple long after the bottle of milk is finished, the habit persisting into early childhood, when they substitute a thumb, several fingers of the hand, or a soft blanket for the rubber nipple.

A young mother should nurse the baby at the breast, and while this is not always possible, there is no reason why the child should not be held in her arms, or the attendant's arms, during the feeding periods. The child feels more secure, and derives more comfort and satisfaction from his bottle, when held in this position. Although psychologically it is a wise procedure, it also has a sound, scientific basis, in that it prevents the infant from swallowing air, prevents choking by injection of milk or water into the trachea, which may happen suddenly and unexpectedly in any child, but is particularly dangerous to the very young, or feeble infant.

Medical advice is of prime importance in the care of infants and children. A physician prescribes the feedings which will satisfy each child, thereby eliminating another possible cause for thumbsucking. It is surprising how many parents will consult a physician for their firstborn, but rely entirely upon their own experience and knowledge for the later children.

If thumbsucking has existed from infancy to the preschool age, it may have been continued because of tensions produced in the home by arguments and bickering of members of the household. The child soon develops feelings of insecurity, which psychologists state is one of the basic causes for tensions which induce thumbsucking. The home atmosphere should be conducive to relaxation. Parents and others should be warned against reminding the child of the habit by "nagging." Disregard thumbsucking, and give the child a chance to forget it.

One must remember that to eradicate a habit of any kind, one must substitute a more satisfactory habit pattern, and so it is in thumbsucking. In young children, this may consist of toy distraction or the addition of more milk in the formula, or extra food in the diet; in the older child, it may consist of participation in play activities which are more satisfying, creating a feeling of belonging to the group, a feeling of adequacy. If there is continued emotional tensions in the environment, they should be "tracked down," and eradicated. Every member of the household can contribute toward this.

At bedtime, the parents or attendant should

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see that the child is warm, dry, and comfortable. One may put the small child to bed and, when tucking him in, see that he has a small doll or teddy bear to cuddle before dropping off to sleep. See that the room is well ventilated and one which is not too far off from the "grown-up." Have the child go to bed in a happy, tension-free atmosphere.

REFERENCES

American Academy of Pediatrics. "Round Table Discussion on Sucking Habits and Deformities of Dental Arches." *Journal of Pediatrics*, July 1940, p. 122.

Mitchell, Harriet. "Thumbsucking: a Practical Appraisal from the Mental Hygiene and Orthodontic Points of View." *Canadian Medical Association Journal*, June 1941, p. 612.

Morgan, J. B. Child Psychology. Farrar and Rinehart, Inc., New York, 1945.

Roberts, Ena. "Thumb and Finger Sucking in Relation to Feeding in Early Infancy." *American Journal of Diseases of Children*, July 1944, p. 7.

Spock, B. M. "A Babies' Doctor Advises about Thumbsucking." *Parents' Magazine*, April 1945, p. 22.

Two Public Health Nursing Societies Meet

On June 10, 1946, the Nursing Committees of the Woonsocket Public Health Nursing Association and the Pawtucket Visiting Nursing Association held a joint meeting at the headquarters of the Pawtucket Visiting Nursing Association in Pawtucket, Rhode Island.

Nine members of each committee, the directors, and representatives of the two nursing staffs were present. The meeting was divided between the two chairmen, each presiding for part of the time. The meeting was arranged because of the many mutual interests and similar problems.

The agenda had been planned to include topics of common interest. Pawtucket Visiting Nursing Association had recently revised its personnel policies and Woonsocket had just completed the revision of its policies, so some time was given to a discussion of any changes. Chief among these changes was the adoption of a 40-hour or 5-day working week. Many of the problems associated with the administration of the new time schedule were cited, among which were the adjustments for Sunday and holiday work.

The Woonsocket group reported on their newest mothers' class, inaugurated at the Federal Housing Unit, an expansion of the antepartum program. Pawtucket described their mothers' classes, and various devices for recruiting expectant mothers were discussed. The importance of stressing good nutrition, ways and means of adjusting menus to meet present-day food shortages, and the use of refreshments as food demonstrations were outlined by the nutritionist on the Pawtucket staff.

The director of the Woonsocket Public Health Nursing Association described the new health and accident group insurance recently adopted by that organization. Pawtucket was interested, because of the fact that it is a participating project, the organization paying one half the premium and the nurse paying the other one half. This is a voluntary and not a compulsory plan.

The chairmen of the Christmas Seal Committees reported, telling of their plans for the coming season. Methods and technics of maintaining an up-to-date mailing list were cited and ideas for enlarging the list were exchanged.

The final topic centered about the content of a good nursing committee meeting. Various members presented their ideas as to the scope and purpose of a nursing committee. Some felt an outside speaker was stimulating, while others liked reports and felt that consideration of related problems of the nursing program should have an important place on the agenda. All agreed that the meetings should not be too long (approximately 1 hour) and should be held at a convenient time and place.

After a delightful luncheon, a tour of the rooms of the Pawtucket Visiting Nursing Association concluded the program. Both groups were unanimous in saying that the meeting had been both interesting and stimulating. They felt that in these days of stress and strain there is much to be gained in sharing ideas as well as in the joint solution of mutual problems. We hope to have other such meetings from time to time.

Theda L. Waterman, R.N., Director
Woonsocket Public Health Nursing Association
Helen J. Marble, R.N., Director
Pawtucket Visiting Nursing Association

NOPHN Ballot — 1946

PRESIDENT AND DIRECTOR* (Vote for one)

1. ☐ Ruth W. Hubbard, R.N., Philadelphia, Pa. ☐ .....
2. ☐ Emilie G. Sargent, R.N., Detroit, Mich. ☐ .....

FIRST VICE-PRESIDENT AND DIRECTOR* (Vote for one)

3. ☐ Ruth B. Freeman, R.N., Minneapolis, Minn. ☐ .....
4. ☐ Ella Mae Hott, R.N., Jefferson City, Mo. ☐ .....

SECOND VICE-PRESIDENT AND DIRECTOR* (Vote for one)

5. ☐ Mrs. F. S. Dellenbaugh, Jr., Litchfield, Conn. ☐ .....
6. ☐ Mrs. David K. Ford, Cleveland, O. ☐ .....

TREASURER AND DIRECTOR*

7. ☐ L. Meredith Maxson, New York, N. Y. ☐ .....

SECRETARY AND DIRECTOR*

8. ☐ Ruth Houlton, R.N., New York, N. Y. ☐ .....

DIRECTORS—NURSE MEMBERS** (Vote for five)

9. ☐ Irene Carn, R.N., New York, N. Y. ☐ .....
10. ☐ Theodora A. Floyd, R.N., Atlanta, Ga. ☐ .....
11. ☐ Ruth A. Heintzelman, R.N., Washington, D.C. ☐ .....
12. ☐ Hortense Hilbert, R.N., New York, N.Y. ☐ .....
13. ☐ Marie L. Johnson, R.N., New York, N.Y. ☐ .....
14. ☐ Donna Pearce, R.N., Richmond, Va. ☐ .....
15. ☐ Ella L. Pensinger, R.N., Worcester, Mass. ☐ .....
16. ☐ Marion W. Sheahan, R.N., Albany, N.Y. ☐ .....
17. ☐ Judith E. Wallin, R.N., New York, N.Y. ☐ .....

DIRECTORS—GENERAL MEMBERS** (Vote for eight)

(Three at least must be chosen from those whose names are in italics, representing board or committee members of public health nursing services or organizations)

18. ☐ *Mrs. Lloyd D. Brace,* Charles River, Mass. ☐ .....
19. ☐ *Mrs. William Bell Cook,* Seattle, Wash. ☐ .....
20. ☐ *Mrs. Gammell Cross,* Providence, R.I. ☐ .....
21. ☐ Jean Alonzo Curran, M.D., Brooklyn, N.Y. ☐ .....
22. ☐ Albert W. Dent, New Orleans, La. ☐ .....
23. ☐ Ira V. Hiscock, Sc.D., New Haven, Conn. ☐ .....
24. ☐ *Mrs. Shepard Krech,* New York, N.Y. ☐ .....
25. ☐ Anson C. Lowitz, New York, N.Y. ☐ .....
26. ☐ *Mrs. L. C. Parks,* Pensacola, Fla. ☐ .....
27. ☐ Rose Schneiderman, New York, N.Y. ☐ .....
28. ☐ *Mrs. Donald C. Shepard,* Neenah, Wisc. ☐ .....

NOMINATING COMMITTEE 1946-48 (Vote for five)

29. ☐ Mrs. Robert G. Bosworth, Denver, Colo.
30. ☐ Zella Bryant, R.N., Washington, D.C.
31. ☐ Irene M. Donovan, R.N., Bismarck, N.D.
32. ☐ Anna C. Gring, R.N., Montclair, N.J.
33. ☐ Julia L. Groscop, R.N., Philadelphia, Pa.
34. ☐ Helen E. Hestad, R.N., Minneapolis, Minn.
35. ☐ Marie M. Knowles, R.N., Brooklyn, N.Y.
36. ☐ Mrs. Langdon T. Thaxter, Portland, Me.

*For 2-year terms.

**For 4-year terms.

Who's Who on the NOPHN Ballot

Officers
President

RUTH W. HUBBARD—Philadelphia, Pa.

Graduate, Army School of Nursing; B.S., Teachers College, Columbia University, New York, N. Y.; graduate work at Yale University and University of Pennsylvania. *Positions held:* staff nurse, VNA, Brooklyn, N. Y.; head nurse, Pediatric Clinic, New Haven Dispensary; assistant instructor and instructor, Yale School of Nursing, New Haven, Conn.; educational director, New Haven VNA. *Past affiliations:* member, Healing Arts and Directory Committees, Pennsylvania SNA, District No. 1, Philadelphia, Pa.; board member, NOPHN Board; chairman, NOPHN Education Committee. *Present affiliations:* member, NOPHN Education Committee; chairman, NOPHN Committee on Accreditation; member, NLNE Accreditation Committee; member, Philadelphia NLNE Board; executive committee member, Nursing Council of Philadelphia; chairman, PSNA Committee on Counseling and Placement, Harrisburg. *Present position:* general director, VNS of Philadelphia.

EMILIE G. SARGENT—Detroit, Mich.

Graduate, Mount Sinai School of Nursing, New York, N. Y.; B.A. and M.S., University of Michigan. *Positions held:* field nurse and assistant director, Visiting Nurse Association, Detroit District Nurses' Association; president, treasurer and vice-president, Michigan State Nurses' Association; board member, American Nurses' Association; president, Michigan Public Health Association; member, Executive Committee of the Study Committee of Voluntary Agencies, National Health Council. *Present affiliations:* member, Michigan Public Health Association; chairman, Michigan Council on Community Nursing; chairman, Joint Committee of the ANA and NOPHN on Nursing in Prepayment Health Plans; member, Nursing Advisory Committee, Metropolitan Life Insurance Company; member, Red Cross Board on Health Services; member, Structure Study Committee, National Nursing Organizations; member, Advisory Council to College of Nursing, Wayne University; member, Public Health Nursing Advisory Committee, University of Michigan; member, Detroit Health Council; 1st vice-president, NOPHN. *Present position:* executive director, VNA of Detroit.

First Vice-President

RUTH B. FREEMAN—Minneapolis, Minn.

Graduate, Mount Sinai Hospital School of Nursing, New York, N. Y.; B.S., Teachers College, Columbia University; M.A., New York University. *Positions held:* private duty nursing, Mount Sinai Hospital; staff nurse, assistant supervisor, and supervisor, Henry Street VNA; part-time instructor, New York University School of Education; instructor in education, New York University; assistant professor, preventive medicine and public health, University of Minnesota. *Past affiliation:* chairman, Minnesota Nurse Association Post War Planning Committee. *Present affiliation:* president, Minnesota Nurse Association. *Present position:* director, course in public health nursing, University of Minnesota.

ELLA MAE HOTT—Jefferson City, Mo.

Graduate, Washington University School of Nursing, St. Louis, Mo.; B.S., Washington University; M.A., Teachers College, Columbia University, New York, N. Y. *Positions held:* educational consultant, Missouri State Board of Health; instructor of public health nursing, Washington University School of Nursing; instructor of nursing, Washington University, Out-patient Department; psychiatric nursing, Missouri State Mental Hospital; industrial nursing, Pittsburgh Plate Glass Company. *Past affiliations:* director, Missouri SLNE Board of Directors; vice-president, 7th District, Missouri SNA, Columbia; secretary, Public Health Nursing Section, Missouri SNA, Jefferson City. *Present affiliations:* president, 7th District, Missouri SNA, Columbia; member, Board of Directors, Missouri SNA, Kansas City; secretary and member of Executive Committee, State Department of Vocational Rehabilitation, Jefferson City; member, Board of Directors, Missouri Association for Social Welfare, Jefferson City; member, Missouri State Crippled Children's Service Advisory Committee, Columbia. *Present position:* director, Division of Public Health Nursing, Missouri State Board of Health.

Second Vice-President

ANNE G. DELLENBAUGH (Mrs. F. S., Jr.)—Litchfield, Conn.

A.B., Smith College, Northampton, Mass. *Past affiliations:* secretary, Board, Boston VNA; member, NOPHN Board of Directors; chairman, NOPHN Board and Committee Members Section; chairman, Legislative Committee, Massachusetts SOPHN; chairman, Advisory Committee on Public Health, Massachusetts Society for Mental Hygiene; board member—Massachusetts Central Health Council, Massachusetts Society for Mental Hygiene, Boston Council of Social Agencies, Boston Health League, Massachusetts Nursing Council; member, Detroit Nursing Council; member, Colony Club, New York, N. Y. *Present affiliation:* member, NOPHN Education Committee.

ELIZABETH BROOKS FORD (Mrs. David K.)—Shaker Heights, Cleveland, Ohio.

Past affiliations: president, VNA of Cleveland;

chairman, Advisory Committee, University Public Health Nursing District, Cleveland; chairman, Cleveland Health Council; board member, The Maternal Health Association of Ohio; volunteer nurses' aide, University Hospitals, Cleveland; trustee, Cleveland Community Fund. *Present affiliation:* 2nd vice-president, NOPHN Board of Directors.

Treasurer

L. MEREDITH MAXSON—New York, N. Y.

A.B., Alfred University; graduate work, Cornell University. *Past affiliations:* vice-president and chairman, Budget Committee, Community Welfare Fund, Bronxville, N. Y.; member, Executive Committee, local post, American Legion, Bronxville; board member and chairman, Finance Committee, Public Health Nursing Organization of Eastchester, Tuckahoe; member, Executive Committee, Westchester County American Red Cross, White Plains; member, University Club, New York. *Present affiliation:* member and chairman of Investment Committee, Alfred University Board of Trustees, Alfred, N. Y.; treasurer and vice-president, First Boston Corporation, New York, N. Y.

Secretary

RUTH HOULTON—New York, N. Y.

Graduate, University of Minnesota, Ancker Hospital, St. Paul, Minn.; postgraduate course in pediatrics and nursing, Child's Hospital, New York, N. Y. *Positions held:* special Red Cross nurse in army hospital and with the Tuberculosis Commission in Italy; nursing field representative with the American Red Cross in Minnesota; superintendent of nurses, Child Hygiene Division, Minnesota State Department of Health; executive director, Visiting Nurse Association, Minneapolis; assistant director, then associate director of the NOPHN. *Present position:* general director of the NOPHN

Directors—Nurse Members

IRENE CARN—New York, N. Y.

Graduate, Johns Hopkins Hospital School of Nursing, Baltimore, Md.; B.S. and M.A., Teachers College, Columbia University, New York, N. Y. *Positions held*: staff nurse, clinic supervisor, supervisor of student field work, East Harlem Nursing and Health Service, New York, N. Y.; consultant in public health nursing, Skidmore College and Mary McClellan Hospital, Cambridge, N. Y. *Present affiliations:* chairman, Joint Committee (NLNE and NOPHN) on Integration of Social and Health Aspects of Nursing in the Basic Curriculum; member, NLNE Curriculum Committee; member, Special Committee to Consider Federal Aid to Nursing Education, National Nursing Council; member, National Council on Red Cross Home Nursing. *Present position:* associate director, Skidmore College Department of Nursing.

THEODORA A. FLOYD—Atlanta, Ga.

Graduate, Los Angeles General Hospital School of Nursing, Los Angeles, Calif.; B.A., Pasadena College, Pasadena, Calif.; M.A., Columbia University, New York, N. Y. *Positions held:* supervising nurse, Hawaii Territorial Department of Health, Honolulu; director, public health nursing course, University of Hawaii, Honolulu; consultant nurse in maternal and child health and associate to state director of public health nursing, Georgia State Department of Public Health, Atlanta. *Past affiliation:* member of Board, Territorial Board of Nurse Examiners, Honolulu. *Present affiliations:* member, Joint (ANA, NLNE, and NOPHN) Committee on Community Nursing Service. *Present position:* regional consultant nurse, Children's Bureau, USPHS.

RUTH A. HEINTZELMAN—Washington, D. C.

Graduate, Children's Hospital School of Nursing, Boston, Mass.; A.B., Wellesley College; M.A., Columbia University. *Positions held:* supervisor, school nursing, Fairmont, West Virginia; field nursing representative for Crippled Children's Services, Pennsylvania Department of Welfare; regional public health nursing consultant, U. S. Children's Bureau; nursing consultant, Procurement and Assignment Service for Nurses, War Manpower Commission; nursing consultant, U. S. Civil Service Commission. *Past affiliations:* member, Public Health Nursing Committee, American Red Cross, Fairmont, West Virginia; chairman of Education Committee, N. Y. SOPHN; member, Committee on the Child, D. C. League of Nursing Education; member, Production Committee on Infant Health, PHN Curriculum Guide; member, NLNE and NOPHN Joint Council on Orthopedic Nursing; chairman, Subcommittee to Study Preparation for Nurses in Orthopedic Field, NOPHN and NLNE; member, Education Committee and Ad Interim Committee, NOPHN. *Present affiliations:* member, NOPHN Education Committee; member, NOPHN Subcommittee on Revision of Qualifications for PHN Personnel; secretary, Council of Federal Nursing Services, Washington, D. C.; member, Nursing Advisory Committee, USPHS, Washington, D. C.; member, Civil Service Committee, Graduate Nurses' Association, Washington, D. C. *Present position:* nursing consultant, U. S. Civil Service Commission.

HORTENSE HILBERT—New York, N. Y.

Graduate, School of Nursing and A.B., University of Minnesota. *Positions held:* staff nurse, Minneapolis Infant Welfare Society; advisory nurse, Poliomyelitis After Care, State Board of Control; advisory public health nurse, Minnesota State Health Department; assistant director, Austrian Child Health Demonstration, The Commonwealth Fund; director for Survey, NOPHN; public health nursing consultant, ACHA; public health nursing consultant, U. S. Children's Bureau; associate director, NOPHN. *Present affiliations:* member, NOPHN Committee on Nursing Administration and NOPHN Maternity and Child Health Council; member, USES Nursing Advisory Committee, New York; member, Board, Na-

tional Nursing Council, ANA Special Committee on Vocational Counseling, Merit System Committee, APHA; chairman, Planning Committee, ICN. *Present position:* director, Bureau of Nursing, New York City Department of Health.

MARIE L. JOHNSON—New York, N. Y.

Graduate, Lutheran Hospital School of Nursing, LaCrosse, Wisc.; B.S., University of Minnesota. *Positions held:* U. S. Army Nurse Corps; laboratory technician, Gundersen Clinic, La Crosse; private duty nurse; staff nurse, Minneapolis VNA; assistant superintendent of Kahler Hospital, Rochester, Minn.; supervisor, IVNS, Washington, D. C.; supervisor of nursing, Eastern Health District and instructor, School of Hygiene and Public Health, Johns Hopkins University, Baltimore. *Past affiliation:* chairman of various committees, Maryland SOPHN, Baltimore. *Present affiliation:* chairman, NOPHN Committee on Nursing Administration. *Present position:* assistant director of nursing, Metropolitan Life Insurance Company.

DONNA PEARCE—Richmond, Virginia

Graduate, University of Pennsylvania School of Nursing; B.S., Teachers College, Columbia University. *Positions held:* associate in charge of public health nursing, field advisory nurse, and public health nurse in Blounts County, Tennessee State Health Department; instructor of nursing, Montgomery Hospital School of Nursing, Norristown, Pa. *Present affiliations:* member, subcommittee of NOPHN Committee on Nursing Administration, and NOPHN Personnel Policies Committee. *Present position:* public health nursing consultant, USPHS.

ELLA L. PENSINGER—Worcester, Mass.

Graduate, Presbyterian Hospital School of Nursing, Philadelphia, Pa.; B.S., Columbia University, New York. *Past positions:* staff nurse and assistant supervisor, Philadelphia VNS; assistant secretary, Associated Out-Patient Clinics, New York; assistant director, Division of Public Health Nursing, Westchester County Health Department, New York; assistant director, NOPHN. *Past affiliations:* member, Board of Directors—Massachusetts SOPHN and Massachusetts Nursing Council for War Service. *Present affiliations:* member, Massachusetts Counseling and Placement Committee; member, Board of Directors, District No. 2, SNA. *Present position:* executive director, District Nursing Society.

MARION W. SHEAHAN—Albany, N. Y.

Graduate, St. Peter's Hospital, Albany, N. Y. *Positions held:* private nursing; child welfare nurse, Cohoes, N. Y.; Henry Street Settlement, New York City; city nurse, Bureau of Health, Albany, N. Y.; county nurse, Niagara County, N. Y.; supervising nurse of tuberculosis, New York State Department of Health; assistant director, Division of Public Health Nursing, New York State Department of Health. *Past affiliations:* chairman, Section on Public Health Nursing, and nurse representative, Committee on Administrative Practice, American Public Health Association; board member, New York State Nurses' Association. *Present affiliations:* member, Executive Committee, Advisory Board on Health Services, and chairman, Subcommittee on Nursing, American Red Cross; president, NOPHN, 1944-46; chairman, Subcommittee on Nursing, New York State Health Preparedness Commission; member, New York State Nursing Council to Board of Regents, New York State Department of Education; member, Board of Directors, National Nursing Council. *Present position:* director, Division of Public Health Nursing, New York State Department of Health.

JUDITH E. WALLIN—New York, N. Y.

Graduate, St. Barnabas Hospital School of Nursing, Minneapolis, Minn.; B.S., Louisiana State University. *Positions held:* staff, Minneapolis VNA; county nursing, American Red Cross, Minnesota; school nurse, Abilene, Texas; Metropolitan Life Insurance Company, Madison, Wisc. and New Orleans, La.; principal chief nurse, 64th General Hospital, A.U.S. *Past affiliations:* president, Louisiana SOPHN; member, Board of Directors, New Orleans Chapter, American Red Cross. *Present position:* Territorial Supervisor, Metropolitan Life Insurance Company.

Directors—General Members

MRS. LLOYD D. BRACE—Charles River, Mass.

Past affiliations: chairman, Greater Boston Community Fund, Dover, Mass.; member, Executive Committee, Massachusetts Nursing Council for War Service, Boston. *Present affiliations:* president, Dover, Medfield and Norfolk VNA; member, Nursing Advisory Committee, McLean Hospital, Waverly, Mass.; member, NOPHN Board and Committee Members Section; NOPHN representative on Nursing Information Bureau.

MRS. WILLIAM BELL COOK—Seattle, Wash.

B.S., University of Indiana; postgraduate, Michael Reese Hospital. *Past affiliations:* various offices, Women's University Club; King County Medical Auxiliary (doctors' wives); several positions on Community Fund committees and war projects. *Present affiliations:* board member and publicity worker, Seattle VNS; member, Associated Women's Health Committee. Author of several articles on public health nursing.

MRS. GAMMELL CROSS—Providence, R. I.

Past affiliations: chairman, NOPHN Board and Committee Members Section; chairman, Nursing Committee, Providence DNA; vice-chairman, Rhode Island SOPHN. *Present affiliations:* vice-president, Providence DNA and member, Nursing Committee, Providence DNA.

JEAN ALONZO CURRAN, M.D.—New York, N. Y.

A.B., Carleton College, Northfield, Minn.; M.D.,

Harvard Medical School. *Positions held:* medical missionary in China; instructor in medicine, director of student health and lecturer in tropical medicine at New York University College of Medicine; attending physician, OPD, Long Island College Hospital; member, Local Appeal Board. *Present affiliations:* member, The American Society of Tropical Medicine; director, The American Foundation for Tropical Medicine, Inc.; secretary, New York Committee on the Study of Hospital Internships and Residencies; member, Committee on Medical Education and Program and Planning Committee, Association of American Medical Colleges; member, Advisory Committee, Brooklyn Cancer Committee of the American Cancer Society; chairman, Christian Medical Council for Overseas Work. *Present position:* president and dean, Long Island College of Medicine, Brooklyn.

ALBERT W. DENT—New Orleans, La.

A.B., Morehouse College, Atlanta, Georgia. *Affiliations:* member, Advisory Committee, National Association of Colored Graduate Nurses; member, Committee on Negro Program, National Tuberculosis Association; member, Commission on Services to Children in War Time, Children's Bureau; member, National Advisory Committee, United Seamen's Service. *Positions held:* superintendent, Flint-Goodridge Hospital of Dillard University; member, NOPHN Board; member, Commission on Hospital Care, American Hospital Association; fellow, American College of Hospital Administration. *Present position:* president, Dillard University, New Orleans.

IRA V. HISCOCK, Sc.D.—New Haven, Conn.

B.A., M.A., Sc.D., Wesleyan University; C.P.H., M.A., Yale University. *Past affiliations:* chief, Public Health Section, U. S. Army Civil Affairs Division, Washington, D. C.; member, Governing Council, APHA; president, National Health Council; board member, NOPHN. *Present affiliations:* member, APHA Committee on Administrative Practice; co-chairman, APHA Committee on State Health Studies; board member, NTA, ASHA, NSPB; board member, New Haven Board of Health; Advisory Committee, New Haven VNA; chairman, Health Education Committee, ARC National Medical Advisory Committee, Washington, D. C.; chairman, Department of Public Health and chairman of University Board of Health, Yale University. *Present position:* professor, Public Health, Yale University School of Medicine.

MRS. SHEPARD KRECH—New York, N. Y.

Past affiliations: member and committee worker, Junior League of N. Y.; vice-president, Speedwell Society, New York; board member, Virginia Day Nursery, New York. *Present affiliations:* president, Maternity Center Association; committee member, Citizens Committee Neighborhood Health Association; committee member, Citizens Planning Committee, National Health Council.

ANSON C. LOWITZ—New York, N. Y.

B.S., Wesleyan University; Graduate School, New York University. *Past affiliations:* Head of Task Force for Recruitment of Cadet Nurses, Army Nurses, Navy Nurses, Red Cross Nurses' Aides, Veterans' Administration Nurses of War Advertising Council, New York and Washington; publicity director, War Finance Committee, Greenwich, Conn. *Present affiliations:* publicity chairman, Alumni Council, Wesleyan University, Middletown, Conn.; member, Advisory Council, Projected Books, Inc., Ann Arbor, Mich.; Head of Task Force for Recruitment of Civilian and Federal Nurses and Public Health Nurse Program of Advertising Council, New York and Washington. *Present position:* vice-president, J. Walter Thompson Company.

MRS. L. C. PARKS—Pensacola, Florida

Graduate, Sweet Briar College, Virginia; B.A., University of Chattanooga, Tennessee. *Past affiliations:* director, Community Chest Board; committee chairman, deputy commissioner, commissioner, Girl Scouts; vice-chairman, camp chairman, Juliette Lowe Region, Girl Scouts; vice-president and president, American Association of University Women, Pensacola; chairman of Volunteers, USO-YWCA, Pensacola. *Present affiliations:* president, Pensacola VNA; chairman, Interracial Committee, Gulf Health and Welfare Council; VNA representative, Pensacola Community Chest Board; chairman, Operating Board, USO-YWCA; chairman, Nominating Committee, YWCA; Pensacola chairman, dances for Cadets on Naval Air Training Bases; chairman, Speakers Bureau and Motor Corps, Pensacola Red Cross.

ROSE SCHNEIDERMAN—New York, N. Y.

Positions held: representative, Paris Peace Conference, representing labor conditions of American working women; delegate, First International Working Women's Congress, Washington, D. C.; delegate, International Congress in Vienna; member, Labor Advisory Board, National Recovery Administration. *Past affiliations:* director, Brookwood Labor College, Katonah, N. Y.; board member, Bryn Mawr Summer School for Working Women; general organizer, International Ladies' Garment Workers Union; committee member, Central Trade and Labor Council for Establishment of N.Y.C. Labor Party; secretary, N. Y. State Department of Labor. *Present affiliations:* president, National Women's Trade Union League; president, New York Women's Trade Union League; member, United Cloth Hat and Cap Makers' Union Local 23; member, New York State War Finance Executive Committee; member, Board of Directors, American Women's Voluntary Services; member, Board of Directors, NOPHN; member, Board of Directors, New York Public Education Association. *Present position:* president, New York Women's Trade Union League.

SYLVIA S. SHEPARD (Mrs. Donald C.)—Neenah, Wisc.

B.A., Smith College, Northampton, Mass. *Past affiliations:* secretary, president, Neenah-Menasha VNA; president, Emergency Society, Neenah, Wisc.; president, Nicolet Parent-Teacher Association, Neenah, Wisc. *Present affiliations:* director, Neenah-Menasha VNA; member, NOPHN Board of Directors; vice-chairman, Lay Section, Wisconsin SOPHN; Red Cross Nurses' Aide.

Nominating Committee 1946-1948

MRS. ROBERT G. BOSWORTH—Denver, Colo.

Past affiliations: president, Denver VNA; chairman, Child Welfare Advisory Committee of Colorado; chairman, Colorado PHN Lay Auxiliary; board member, NOPHN. *Present affiliations:* chairman, Entertainment Committee, American Red Cross Camp and Hospital Committee; board member, Denver VNA; board member, Denver Public Health Council; board member, Colorado Public Health Association.

ZELLA BRYANT—Chicago, Ill.

Graduate, Kentucky Baptist Hospital School of Nursing, Louisville, Ky.; B.S., George Peabody College, Nashville, Tenn. *Positions held:* associate public health nurse consultant, USPHS, District No. 3; assistant chief nurse, U. S. Office of Civilian Defense; assistant public health nurse consultant, USPHS, District No. 4; representative, field nursing and assistant to director, Nursing Service, ARC. *Present affiliations:* member, Nominating Committee, NOPHN. *Present position:* director, nursing, Labor Branch, U. S. Department of Agriculture.

IRENE M. DONOVAN—Bismarck, N. D.

Graduate, St. Joseph's Hospital School of Nursing, St. Paul, Minn.; B.S., University of Minnesota, Minneapolis. *Positions held:* supervisor, Infant Welfare Society, Minneapolis; assistant director, Maternity and Child Health, State Health Department, Bismarck, N. D.; supervisor, IVNA, Washington, D. C.; assistant supervisor, State Health Department, Bismarck, N. D.; director, public health nursing, State Health Department, Bismarck, N. D. *Past affiliations:* president, Lewis and Clark DNA, Bismarck, N. D.; chairman, Procurement and Assignment Committee, North Dakota State War Council; member, League of Nursing Education, Washington, D. C.; member, North Dakota State League of Nursing Education. *Present affiliations:* chairman, Program Committee, State League of Nursing Education; vice-president, State Public Health Association; member, APHA. *Present position:* director, Public Health Nursing, North Dakota State Health Department.

ANNA C. GRING—Montclair, N. J.

Graduate, Homeopathic Hospital School of Nursing, Reading, Pa.; B.S., Teachers College, Columbia University. *Positions held:* staff nurse, VNA, Reading, Pa.; public health nurse, Visiting Nurse and Child Welfare Association, Salem, N. J.; educational director, VNA, Springfield, Mass.; nursing consultant, Massachusetts, Rhode Island and Vermont, ARC; assistant director, NOPHN; assistant director, Red Cross Home Nursing, ARC. *Past affiliations:* chairman, Program Committee, SOPHN; member, Committee to Study Supervising in School Nursing; member, Records Committee, NOPHN. *Present affiliations:* chairman, Maternity, Infant and Preschool Section, SOPHN; member, Health Committee, New Jersey Welfare Council; vice-chairman, Disaster Committee, Montclair Chapter, ARC; member, Nurses' Aide and Nutrition Committee, ARC; member, Board, Montclair Guidance Center; member, Planning Committee, Montclair Council of Social Agencies and Dental Health Committee; member, Eligibility Committee, Subcommittee on Cost Analysis, and Committee on Administration Practice, NOPHN; member, Advisory Committee Public Health Nursing Program, Seton Hall College. *Present position:* director, Bureau of Public Health Nursing, Montclair.

JULIA L. GROSCOP—Philadelphia, Pa.

Graduate, University of Michigan School of Nursing; B.S., Teachers College, Columbia University. *Positions held:* staff nurse, Detroit VNA; staff nurse, Detroit Department of Health; public health nurse, DeKalb County, Indiana; nurse field representative, National Red Cross; associate public health nurse consultant, USPHS; executive secretary, Nursing Council for War Service, Philadelphia. *Past affiliations:* vice-president, District No. 1, Indiana SNA, Fort Wayne, Ind.; chairman, Committee to Study Relationships between Official and Voluntary Agencies, PHN Section, APHA; vice-chairman, National Committee Health Council Executives; committee member, S. E. Pennsylvania Chapter, American Red Cross, Philadelphia; executive secretary, Procurement and Assignment Committee, Philadelphia. *Present affiliations:* committee member—National Committee Health Council Executives, Nursing Council in metropolitan Philadelphia, and several local agencies. *Present position:* consultant, Health Division, Council of Social Agencies, Philadelphia and vicinity.

HELEN E. HESTAD—Minneapolis, Minn.

Graduate, Kahler Hospitals School of Nursing, Rochester, Minn.; B.S., University of Minnesota. *Past positions:* school nurse, in the states of Wisconsin and Minnesota; educational director, Infant Welfare Society; maternal and child health consultant, Community Health Service; acting director and assistant director, Community Health Service—all Minneapolis. *Past affiliations:* president, Minneapolis Nurses' Association; president, Minnesota SOPHN; board member, Minnesota Nurses' Association. *Present affiliations:* board member and chairman, Personnel Policies Committee, Minneapolis Nurses' Association; board member and member, Education

(Continued on page 370)

Proposed Revisions of NOPHN Bylaws

AT THE Biennial meeting of the National Organization for Public Health Nursing in Atlantic City, New Jersey, during the fourth week in September, a meeting of the members will be held on September 27 at 9:30 a.m. at which time the following proposed amendments to the bylaws will be presented for adoption:

PRESENT BYLAWS

ARTICLE I

Membership

Section 1. Classes of Membership

The membership of this corporation shall consist of two classes:

Class A—Individual

1. Nurse Members

Any graduate nurse complying with the state law for registration of nurses may become a member.

2. General Members

Any non-nurse individual interested in public health nursing may become a member.

3. Sustaining

Any individual may become a sustaining member.

4. Life

Any individual may become a member for life.

5. Honorary

Honorary membership may upon recommendation of the Board of Directors be conferred by unanimous vote at any convention of the members upon those who have rendered distinguished service, or valuable assistance to the nursing profession or to public health.

Honorary membership shall not be conferred on more than two persons at one convention.

Class B—Agency

1. Agency

Organizations or other groups administratively engaged in public health nursing may become agency members.

2. Associate Agency

Organizations or other groups interested but not administratively engaged in public health nursing may become associate agency members.

Applicants for nurse, agency, and associate agency membership shall submit applications to the Secretary which shall be referred to the Eligibility Committee. After approval by the Eligibility Committee, the applicant shall become a member upon payment of dues as hereinafter provided.

Applicants for general and sustaining membership shall become members upon payment of dues as hereinafter provided.

PROPOSED AMENDMENTS

That ARTICLE I be amended to read as follows:

Membership

Section 1. Classes of Membership

The membership of this corporation shall consist of two classes:

Class A—Individual

1. Nurse Members

Any graduate nurse complying with the state law for registration of nurses may become a member.

2. General Members

Any non-nurse individual interested in public health nursing may become a member.

3. Sustaining

Any individual may become a sustaining member.

4. Life

Any individual may become a member for life.

5. Honorary

Honorary membership may upon recommendation of the Board of Directors be conferred by unanimous vote at any convention of the members upon those who have rendered distinguished service, or valuable assistance to the nursing profession or to public health.

Honorary membership shall not be conferred on more than two persons at one convention.

Class B—Agency

1. Agency

Organizations or other groups administratively engaged in public health nursing may become agency members.

2. Associate Agency

Organizations or other groups interested but not administratively engaged in public health nursing may become associate agency members.

Section 2. Procedure for Application

1. Applicants for nurse and agency membership shall submit applications to the Secretary which shall be referred to the Eligibility Committee. After approval by the Eligibility Committee, the applicant shall become a member upon payment of dues as hereinafter provided.

Applicants for life membership shall become members upon payment of dues and may become members upon payment of dues in part if authorized by the Board of Directors.

Section 2. Dues

The following are the dues, according to class of membership:

1. The annual dues of nurse members and general members shall be $3.

2. The dues of life members shall be $100, payable within one year from date of application. Such payment confers the privileges of membership for life.

3. The annual dues of sustaining members shall be $10, or more at the member's option.

4. The annual dues of an agency member shall be an amount equal to one percent of its total expenditures for public health nursing service in its fiscal year last preceding the calendar year for which such dues are payable (minimum dues $10 if the nursing staff is less than five and $25 if the nursing staff is five or more).

5. Annual dues of associate agency members shall be $5.

All annual dues shall be paid for each calendar year on or before January 1st of such calendar year.

6. Honorary members shall pay no dues.

The membership of any member in arrears in payment of dues for 60 days shall automatically cease but may be reinstated upon payment of arrears.

ARTICLE V

Committees

Section 1. Standing Committees

The following standing committees shall be appointed every two years at or after the Biennial Convention.

1. Executive Committee

The Executive Committee shall be composed of the President, First Vice-President, Second Vice-President, Secretary, Treasurer, and eight other members of the Board of Directors, chosen by the Board, of whom four shall be nurse members and four other members. The Executive Committee shall have general supervision and direction of the affairs of the corporation, and shall exercise all the powers of the Board of Directors which may lawfully be delegated between meetings of the Board. Meetings of the Executive Committee may be called at any time by the President, and shall be called by her upon request of three members of the Executive Committee. Notices of meetings of the Executive Committee shall be mailed by the Secretary not

2. Applicants for general, sustaining, associate agency, and life membership shall become members upon payment of dues as hereinafter provided.

Section 3. Dues

The following are the dues, according to class of membership:

1. The annual dues of nurse members and general members shall be $3.

2. The dues of life members shall be $100, payable in full with application or within one year from date of application. Such payment confers the privileges of membership for life.

3. The annual dues of sustaining members shall be $10, or more at the member's option.

4. The annual dues of an agency member shall be an amount equal to one percent of its total expenditures for public health nursing service in its fiscal year last preceding the calendar year for which such dues are payable (**minimum dues $10** if the nursing staff is less than five; $25 if the nursing staff is five but less than ten; $50 if the nursing staff is ten or more).

5. Annual dues of associate agency members shall be $10.

6. Honorary members shall pay no dues.

7. Annual dues are on a calendar year basis.

8. The membership of any member in arrears in payment of dues for 60 days shall automatically cease but may be reinstated upon payment of dues for any year.

That Section 1 of ARTICLE V be amended to read as follows:

Committees

Section 1. Standing Committees

The following standing committees shall be appointed every two years at or after the Biennial Convention.

1. Executive Committee

The Executive Committee shall be composed of the President, First Vice-President, Second Vice-President, Secretary, Treasurer, and eight other members of the Board of Directors, chosen by the Board, of whom four shall be nurse members and four other members. The Executive Committee shall have general supervision and direction of the affairs of the corporation, and shall exercise all the powers of the Board of Directors which may lawfully be delegated between meetings of the Board. Meetings of the Executive Committee may be called at any time by the President, and shall be called by her upon request of three members of the Executive Committee. Notices of meetings of the Executive Committee shall be mailed by the Secretary not

less than five days before any such meeting. A quorum shall consist of five members.

2. Nominating Committee

The Nominating Committee shall be composed of five members elected by the members at the Biennial Convention to serve until the next Biennial Convention. The Committee shall choose its own chairman. It shall be the duty of this committee to nominate one or more candidates for each membership of the Board of Directors and for each of the officers of the corporation and ten candidates for the Nominating Committee. The report of the Committee shall be filed with the Secretary at least six weeks before the convention and shall be sent to all members with notice of such election at least one month before the convention.

3. Finance Committee

The Finance Committee shall consist of such persons as may be appointed thereto by the Board of Directors. It shall be the duty of this committee to consider and recommend means of securing adequate income for the corporation, to recommend an annual budget to the Board of Directors, and to advise on the financial problems of the corporation from time to time.

4. Eligibility Committee

The Eligibility Committee shall be chosen by the Board of Directors and one of them shall be designated as chairman. This committee shall have the duty and power to determine the eligibility of applicants for membership and to pass upon all membership applications.

less than five days before any such meeting. A quorum shall consist of five members.

2. Nominating Committee

The Nominating Committee shall be composed of five members, three of whom shall be nurse members and two of whom shall be general members, elected by the members at the Biennial Convention to serve until the next Biennial Convention. The Committee shall choose its own chairman. It shall be the duty of this committee to nominate one or more candidates for each membership of the Board of Directors and for each of the officers of the corporation and ten candidates for the Nominating Committee, six of whom shall be nurse members and four of whom shall be general members. The report of the Committee shall be filed with the Secretary at least six weeks before the convention and shall be sent to all members at least one month before the convention.

3. Finance Committee

The Finance Committee shall consist of such persons as may be appointed thereto by the Board of Directors. It shall be the duty of this committee to consider and recommend means of securing adequate income for the corporation, to recommend an annual budget to the Board of Directors, and to advise on the financial problems of the corporation from time to time.

4. Eligibility Committee

The Eligibility Committee shall be chosen by the Board of Directors and one of them shall be designated as chairman. This committee shall have the duty and power to determine the eligibility of applicants for membership and to pass upon all membership applications.

The foregoing proposed amendments have been approved by the Executive Committee of the Organization.

MARION W. SHEAHAN, R.N., President
RUTH HOULTON, R.N., Secretary

Who's Who on NOPHN Ballot

(Continued from page 367)

Committee and Personnel Policies Committee, SOPHN, St. Paul; member, Home Nursing Advisory Committee, Hennepin County Red Cross. *Present position:* assistant director, Community Health Service.

MARIE M. KNOWLES—New York, N. Y.

Graduate, Newton Hospital School of Nursing, Newton, Mass.; B.S., Simmons College; A.B., Smith College. *Positions held:* assistant dean, Bates College, Lewiston, Maine; director, Newton DNA, Newton, Mass.; staff nurse, assistant supervisor, supervisor, and assistant director, Boston Community Health Association, Boston, Mass. *Present position:* executive director, Brooklyn VNA, New York, N. Y.

PRISCILLA K. THAXTER (Mrs. Langdon T.)—Portland, Me.

Past affiliations: president, Council of Social Agencies, Portland; vice-president, Community and War Chest, Portland; chairman, Maine Social Protection Committee. *Present affiliations:* board member, Portland DNA; member, Advisory Committee, State Department of Health and Welfare; member, Advisory Committee, State Department of Nursing; member, Executive Committee and Board of Directors, NOPHN.

Reviews and Book Notes

NURSING AND NURSING EDUCATION

By Agnes Gelinas, R.N. 72 pp. The Commonwealth Fund, New York, 1946. $1.00.

This small volume, one of a series of monographs, published by the Commonwealth Fund and issued under the auspices of the Committee on Medicine and the Changing Order of the New York Academy of Medicine, presents in simple and direct manner the major trends in the past, present and future development of the profession of nursing. The monograph is directed primarily to a non-nurse reading public; however, nurses will find it a valuable ready reference. Miss Gelinas has presented clearly many of the problems and opportunities before the profession. She has expressed largely the philosophy of nursing and nursing education as accepted by our national organizations and by progressive leaders in the profession and in the health and medical fields. At the close of each chapter authoritative sources are listed. A well classified index is included.

It is hoped that this volume and others similar to it which may be published will have large circulation as they will undoubtedly bring about a better understanding of the present problems and future needs of nursing and nursing education, as pointed out by Mrs. August Belmont in her sympathetic preface to the book.

—ANNA D. WOLF, R.N., *Director, School of Nursing and Nursing Service, Johns Hopkins Hospital, Baltimore.*

THE SERVICE LOAD OF A STAFF NURSE IN ONE OFFICIAL PUBLIC HEALTH AGENCY

By Marion Ferguson, Ph.D. 51 pp. Bureau of Publications, Teachers College, Columbia University, New York, 1945. $1.85.

Students in public health nursing administration will welcome the excellent historical summary of literature on the improvement of efficiency of personnel in Chapter 2 of Miss Ferguson's comprehensive survey.

The use of the technique of microfilming is one practical answer to the difficult problem of record analysis which as it becomes less expensive could be used by both large and small agencies. But there is as yet no magic available even in the word "formula". To apply the Ferguson formula for a service load, it is necessary to go through all the preliminary steps of analyses and then the need for such a formula may be questioned. For example, the statistician would ask such questions as; what is to be used for N in applying this formula to future estimates; how can you tell what V or P are until the nurse has made her visits; why are computations relating to time spent in the home carried to the second decimal when other equally important factors, such as travel and office time, are based on a single average value from a previous study?

The statistical appearance and terminology of Miss Ferguson's study should be welcomed. We need more such studies. This one emphasizes the point that the public health nurse is capable of only so much work and that additional pressures in one area must result in lessened responsibility in another. The analysis of practice gives an excellent picture of content of visits and ample material to indicate needed changes in emphasis in the staff education program of an agency. This kind of analysis can also be used to show the need for advice from specialists to improve the quality of service.

—MARIAN G. RANDALL, *Executive Director, Visiting Nurse Service of New York.*

WHERE DO PEOPLE TAKE THEIR TROUBLES?

By Lee R. Steiner. 265 pp. Houghton Mifflin Company, Boston, 1945. $3.00.

For a number of years Miss Steiner questioned, "Where do people who aren't poor take their troubles?" To those who have the same question, this book will be interesting and enlightening. Facts about movements and programs by groups or individuals we have read of, or listened to, are presented with some interpretation by the writer.

The report is introduced by a very brief presentation of "Who is a psychologist?"

As the book progresses there is a mingling of facts gleaned from the study with counseling advice that might well be confusing to the non-professional reader.

Repeatedly you see "How people feel about themselves and the world in which they live." It is indeed a "pageant of troubled souls seeking—seeking—seeking," from "Gremlins in the Inkpot", "Men of Letters", "Entrepreneurs for Cupid", "Sellers of Doves", "Lines of Destiny", to "Personality on Sale" etc.

The nurse who reads this report will not fail to ask herself this question, "Do I always take the time to listen, commend, encourage, interpret, express interest, sympathy and understanding as often as it is needed?"

—CAROLINE E. FALLS, R.N., *Assistant Director, Department of Educational Nursing, Community Service Society of New York.*

MEN WITHOUT GUNS

By DeWitt Mackensie. 47 pp. Illustrated with 118 plates in color. The Blakiston Company, Philadelphia, 1945. $5.00.

This book is a graphic account of war surgery and an incredibly moving history of war art. It is the story of Army Medical Corps seen through the eyes of twelve famous contemporary artists commissioned by the Abbott Laboratories to set on canvas their interpretations of what they saw in Army hospitals in the Zone of Interior, on the landings with invasion forces, on the beachheads of Europe and in the jungles of the Pacific.

The history of the Medical Department in World War II has been captured for posterity in the one hundred and eighteen color plates, reproductions of their vivid paintings. Innumerable pictures, both still and movie, have been filmed during this war but few can compare in startling reality to this artistic documentation of the chain of evacuation of Army battle casualties.

These authentic and sometimes grim pictures are a permanent tribute to the personnel who comprise the U. S. Army Medical Department: the enlisted corpsmen, the medical officer and the army nurse, whose praise so well blended in oil and watercolors, makes this a memorable book.

—FLORENCE A. BLANCHFIELD, COLONEL, AUS, *Superintendent, ANC, Army Service Forces, Office of the Surgeon General, Washington, D.C.*

PRINCIPLES OF SOCIAL CASE RECORDING

By Gordon Hamilton. 142 pp. Published for the New York School of Social Work by Columbia University Press, New York, 1946. $2.00.

I enjoyed reading the 1946 material by Dr. Hamilton and believe that public health nurses who are interested in better case recording will both enjoy the book and get much help from it. Dr. Hamilton follows her own advice in writing lucidly, economically, accurately,—three words she has chosen to use in previous publications about case recording. In the new book she adds the ideas for making the writing objective and usable.

The following excerpts indicate the philosophy of the book: "The novice is not likely to achieve a short, well-selected record until he has been taught to produce a thoughtful, complete one." "It is not the recording which is difficult; it is the thinking which precedes it." "The word 'diagnosis' means thorough understanding, and although the term has been pre-empted by medicine, actually it is a good Greek word susceptible of general application, until some better term is invented. As used in social work, it means not only understanding the problem, but the person who has the problem." In speaking of medical social records, the author says, "The meaning of the patient's illness to him as a unique person in his own peculiar situation should be clearly presented and the social material should be organized and arranged so that it will effectively point up its relation to medical-social diagnosis and treatment."

The paragraph headed "Reasons for Recording" is of particular interest. The author states that writing of good records tends to improve the practitioner's skill and to make the profession as a whole increasingly effective. Subject matter must be communicable so that each new worker does not have to learn by trial and error. The practitioner must be constantly student and critic of his work. No way is more likely to make us think than to have to write out our reflections. Another essential is to learn to analyze and interpret the data, and to record one's thinking in the case record. Because records are used in agencies and because there is considerable mobility and turnover in most staffs, responsible shared accounts become invaluable.

The last sentence in the book summarizes aptly, "In an ultimate sense only the trained

diagnostician can write a good record, for only he can pluck from the unending web of social experience the thread of probable significance."

—Dorothy E. Wiesner, *Statistician, NOPHN.*

A FUTURE FOR PREVENTIVE MEDICINE

By Edward J. Stieglitz, M.S., M.D., F.A.C.P. 77 pp. The Commonwealth Fund, New York, 1945. $1.00.

This monograph will be of interest to public health workers and medical practitioners alike. As Doctor Stieglitz points out, the past and present triumphs of preventive medicine have been attained largely by measures undertaken on a mass basis requiring little or no personal effort on the part of the public. Nor have these measures required much individualization of techniques. Because of our ageing population, the problems of control of degenerative diseases will increasingly outweigh the problems of acute infectious diseases of youth that have demanded our attention in the past. Methods will have to be changed and greater emphasis given to health education. The results will depend on further research into the etiology of degenerative diseases; ability of physicians to practice "constructive" medicine; and willingness of the individual to exercise initiative in seeking guidance for his health problems.

This concise monograph is the result of much study and thought, and the conclusions are a challenge to all workers in preventive medicine.

—Martin Mills, M.D., *Commissioner of Health, City of Richmond, California.*

OUR INNER CONFLICTS

By Karen Horney, M.D. 250 pp. W. W. Norton & Co., Inc., New York, 1945. $3.00

This book was written primarily for psychoanalysts who are interested in improving the theory and therapy of their profession. The author also hopes the ideas contained in the book will be used for the benefit of patients and for the expert himself who must be ready for change and growth within himself. Dr. Horney's basic thesis is that "man has the capacity as well as the desire to develop his potentialities and become a decent human being and that these deteriorate if his relationship to others, and hence to himself, is and continues to be disturbed."

She begins with the statement that it is not neurotic to have conflicts—neurosis is always a matter of degree. At one time or another our wishes, our interpretations, our convictions are bound to collide with those of others around us. Conflicts that start with our relation to others in time affect the whole personality. So neurosis is defined as an expression of a disturbance in human relationships. Dr. Horney has evolved the theory that the dynamic center of neurosis is a basic conflict between attitudes of "moving toward," "moving against," and "moving away from" people.

In a world torn asunder by conflicts, Dr. Horney brings us a constructive theory in that she firmly believes man can change and go on changing as long as he lives. Her convictions are based on years of experience in working with patients, broadened by contact with students as a teacher in the Berlin Psychoanalytic Institute, lecturer at the New School of Social Research, as associate director of the Chicago Institute for Psychoanalysis, and now as dean of the American Institute for Psychoanalysis.

—Marguerite Wales, R.N., *author of The Public Health Nurse in Action, (Macmillan Company, New York), Twenty-Nine Palms, Calif.*

GLOBAL EPIDEMIOLOGY: A GEOGRAPHY OF DISEASE AND SANITATION

By James S. Simmons, M.D., Ph.D., Tom F. Whayne, M.D., Gaylord W. Anderson, M.D., Harold M. Horrack, M.D., and Collaborators. 504 pp. J. B. Lippincott Company, Philadelphia, 1944. Volume One. $7.00.

This volume is divided into two parts. Part One applies to India and the Far East and Part Two applies to the Pacific area.

This is a well-edited book which contains more basic factual data regarding disease than probably any other reference book ever printed. It was written primarily as a reference book for medical officers who would be stationed in the various countries in this area. The information from each country follows the same general pattern, with the geology or geography, and climate being taken up in detail. To the student of Epidemiology, this gives an immediate clue to the diseases which might be expected to be present in this area.

Immediately following the section on geography and climate, there is a detailed section

on health services as they existed at the outbreak of war. This includes governmental agencies, both public health and hospital facilities, as well as a general appraisal of the effectiveness of the health services in the area. A full paragraph is devoted to water supplies in each country, giving the number of water systems in the country as well as the source of water supplies and the manner in which treatment was carried out. There is also a full paragraph describing the sewage disposal systems and the water-borne systems are listed along with the other more primitive methods of excreted disposal.

One of the most interesting features of each country as described in "Global Epidemiology" is the section on insects and animals. Mosquitoes, flies, lice, fleas, ticks, mites, roaches, snakes, and other dangerous animals are all described and there is also a brief description of the diseases which each of these animals carries. Pests are also listed and described.

There is one section in the review for each country on the food and dairy products. There is some description of the sanitary provisions provided by the local governments.

The medical facilities for each country are well-described, listing the number of hospital beds, types of equipment, amount of supplies, the number of physicians and their qualifications, nurses, dentists and others. In relation to this there is a description of all the medical institutions, teaching institutions, and the type of facilities which they have and the apparent reliability of various procedures which are carried out in these hospitals and laboratories.

Each country has a section on diseases that are grouped under the following categories:

1. intestinal tract diseases
2. respiratory tract diseases
3. contact diseases
4. diseases spread by arthropodes
5. nutritional diseases
6. miscellaneous conditions

In addition there is always a summary at the end of each chapter on the conditions to be met in that particular country stressing the major problems.

There is one other additional important feature of this book which makes it most valuable as a reference book. There is a complete bibliography at the end of each chapter which is descriptive enough to allow any person to study health conditions on any part of the globe covered by this book. The book is highly recommended for any person who is interested in health conditions in India, the Far East, and the Pacific area whether his interest is from the standpoint of the worker in the field or academic.

—Rufus F. Payne, M.D., M.P.H., *Superintendent, State Tuberculosis Sanatorium, Alto, Georgia.*

RECENT PUBLICATIONS AND CURRENT PERIODICALS

CANCER

Breast Cancer. National Cancer Institute. U. S. Public Health Service, Washington 14, D. C., Bethesda Station. 1945. 9 pp. Free.

Nursing the Cancer Patient. By Franziska Glienke. *The Quarterly Bulletin,* November 1945. Nursing Bureau, Welfare Division, Metropolitan Life Insurance Co., 1 Madison Ave., New York 10.

Cancer of the Digestive Tract. By John J. Creedon. *Hygeia,* February 1946, page 106. The American Medical Association, 535 N. Dearborn St., Chicago 10. Single copy: 25c.

HEARING

Psychological Aspects of Deafness. By Foster Kennedy, M. D. *Hearing News.* American Society for the Hard of Hearing, 1537 35th St., N.W., Washington 7, D. C., February 1945. As Reprint No. 150, it is available for 10c per copy.

Loss of Hearing: information for families and friends of veterans. The American National Red Cross, Washington, D. C. March 1946. Free.

ORTHOPEDIC NURSING

The Extremities. By Daniel P. Quiring, Ph.D., *et al.* Lea and Febiger, Philadelphia, Pa., 1945. 117 pp. $2.75.

Contains 106 illustrated diagrams of muscles, of the upper and lower extremities including origin, insertion, function, and arterial and nerve supply.

Posture. Family Health Series Guide for Public Health Nurses, No. 5. Community Service Society, Department of Educational Nursing, 105 E. 22nd St., New York 10. November, 1945.

Public Information Tips

This is your column. It is a means of exchanging news and views about successful ways and means of interpreting public health nursing service. Help make the column as effective as possible by writing NOPHN about your public information programs. ***E.W.***

WE APPRECIATE the interesting reports about "Know Your Public Health Nurse Week" that are coming to NOPHN from many communities. If yours has not yet been sent, won't you see that it is mailed soon? We need as many reports as possible so that our Magazine article about the "Week" can be comprehensive. We also appreciate the helpful suggestions we are receiving about observing next year's "Week." We only wish we had a million dollars and a large public relations staff to carry them out! We'll do our best, however, to prepare the kind of publicity aids that will prove helpful to the majority of communities.

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Plans for a "Week" in 1947 are going forward, although a budget is not yet assured. Tentatively the time has been set for April 7-13. These are the same dates as for the 1946 "Week" but in 1947 this will be the week after Easter. In selecting this time NOPHN has tried to avoid insofar as possible other national observances. We are sorry that it is difficult to find a time that is 100 percent right for every community. However, if you foresee that April 7-13 in 1947 will be a very unfortunate time, we shall appreciate your letting us know.

• • • •

A special recording of the Helen Hayes program "Crusader on Call," which was broadcast over the Columbia Broadcasting System April 9 during "Know Your Public Health Nurse Week," may now be borrowed from NOPHN. This, you remember, is a dramatization of some incidents in the life of Lillian Wald when she was organizing a public health nursing service for New York's Lower East Side. The recording can be played at community meetings but may not be used for rebroadcast on any radio programs. Communities borrowing these recordings are urged to make sure they have special playback machines that revolve at exactly 33⅓ revolutions a minute. They also are urged to test the machine and the recording in advance of any public playing. If the machine revolves at too fast or too slow a speed, the recording is useless. Playing time is 30 minutes; rental charge $2.

Comes a time in the life of every agency when the annual report is due. This can be a last-minute rush to get something out just to fulfill an obligation, or it can be a very satisfying moment when you feel you have made the best of an opportunity to increase your community's understanding of what you really do and hope to do in the future. A very helpful booklet "Annual Reports, How to Plan and Write Them," by Beatrice K. Tolleris, has just been published by the National Publicity Council. As a special service for its members NOPHN has secured a supply of these publications and is offering them to individual and agency members at the special price of 75 cents ($1.00 to non-members). Although annual report time may seem way off in the future, we recommend that you send for your copy now. Then it will be right on your desk when you need it.

• • • •

A new supply of the 8-page leaflet "Know Your Public Health Nurse" has just come off the Metropolitan Life Insurance Company's press. Communities may order these in quantities up to 500. The leaflets are free, but there is a charge for postage and handling: East of Mississippi, for 300-500 leaflets, 65 cents; 10-299, 25 cents; West of Mississippi, 300-500, $1.10; 50-299, 65 cents; 10-49, 25 cents. To save billing and bookkeeping costs, it is requested that payment for postage and handling accompany orders.

• • • •

Word comes from Philadelphia that the first Philadelphia nurse to be televised is Mrs. Violette Kelly who recently enacted the "Girl with the Little Black Bag" over station WPTZ on Armand Spitz's program "Shoes and Ships." During this program Mrs. Kelly demonstrated the use of much of the equipment in the bag, and described the kind of nursing care that a public health nurse can give in the home. It is hoped that this initial venture may be the first in a series of health education programs. We wonder if this is the first time in the entire country that a public health nurse has been "televised." If there have been similar radio programs, won't you let us know?

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Hedwig Cohen

HEDWIG COHEN JOINS STAFF

Hedwig Cohen joined the staff of the NOPHN July 1 as assistant director. Her duties will include vocational counseling and editorial assistance in the publication of PUBLIC HEALTH NURSING magazine. A graduate of St. Mark's Hospital School of Nursing, New York, Miss Cohen holds a bachelor's degree in public health nursing from Columbia University. Her wide background of nursing experience includes both institutional and public health nursing. Miss Cohen comes to National Headquarters from Washington, D.C., where she was educational director with the Instructive Visiting Nurse Association. Prior to joining the IVNA staff in 1942 she was, successively, staff nurse, assistant supervisor, supervisor, and educational assistant, Henry Street VNS (now VNS of New York).

SIX JOINT SESSIONS AT BIENNIAL

"Nursing in National Health Planning" has been chosen as the general theme of the 1946 Biennial Nursing Convention at Atlantic City, September 23-27. Discussions in six joint sessions throughout the week will be devoted to different phases of the central topic as follows:

Monday evening, September 23—"Definition of Nursing." A nurse, a physician, and a representative of the public which uses and pays for nursing service will present their views.

Tuesday evening, September 24—"National and International Horizons in Health." Dr. Thomas Parran, Surgeon General, USPHS, in developing this subject, will emphasize the nursing service needs of the nation and the world. "Social Problems Facing the World Today" will be outlined by a second speaker.

Wednesday morning, September 25—Two joint meetings are planned, one on "Planning for Community Nursing Service," to be arranged by the Joint Committee on Community Nursing Service, and another on "Trends in Personnel Administration." Presentation of the latter timely subject will set the stage for later conferences of special groups.

Wednesday evening, September 25—Fiftieth Anniversary Celebration, ANA. Details will be announced later.

Thursday evening, September 26—The question, "Who shall pay for nursing education," will be discussed by a panel of distinguished speakers.

Friday afternoon, September 27—"Nursing Service in Longterm Illness." A panel of speakers, representing both the medical and nursing professions, will participate.

NOPHN BUDGET APPROVED

The NOPHN budget, in process of review by the Budget Committee of the National Community Chests and Councils during recent weeks, has received full approval and endorsement, announces Ruth Houlton, general director. This is a most important development for executives and boards of affiliated agencies to watch, as they will want to be prepared to include in their budgets to chests for the fall campaign the total amount of NOPHN dues—one percent—specified in the bylaws but not yet achieved by many agencies.

The CC and C Budget Committee, established in 1942 to review foreign relief and war service appeals

(transferred to the National War Fund in 1943) has now been re-formed on a peacetime basis. Principles and policies for the functioning of the new committee have been set forth as follows: (1) it will review budgets of national organizations making appeals to local chests (2) it will provide a vehicle for national agencies through which their proposals may be tested, proved, endorsed, and recommended to local chest communities (3) it will not become a device to dominate national agencies by the imposition of fiscal controls nor one whereby local communities can avoid meeting responsibility for support of appropriate national programs (4) its constructive purpose is to provide national agencies with an orderly medium through which their budgets may be expressed and their requests for support channeled to local communities. (See *Community*, May 1946, p. 16.)

This action of the national Community Chests and Councils is very important to the NOPHN, in view of the great variation in (1) the percentage of dues received through local chests by national agencies and (2) the interpretation of the help given by national organizations to local programs.

Receiving part of its operating budget from agency dues through local chest support, NOPHN is affected by these variants. With the hope of clarifying this situation and increasing agency dues with approval of local chests, NOPHN submitted the actual 1946 and tentative 1947 budgets to the national reviewing committee, and their approval has been announced. While the national CC and C does not propose to exercise control over local chest budgets, there is indication that approval of the NOPHN budget will strengthen the Organization's position in many chest cities. Individual chests will be informed of the action of this committee, and this budget review will be a means of further interpretation of national programs which infiltrate into local community planning for health and welfare.

Local public health nursing agencies have sometimes been hesitant about including the full amount for NOPHN dues in their budgets when presented to chests. If the fall drives are to include adequate amounts for the community share in national agencies, which by consultant services strengthen the local program, now is the time to emphasize the need of this inclusion of the full one percent of nursing costs to executive committees of boards and chests.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Ruth Fisher	Oak Park, Ill.—July 10-24
Eleanor Palmquist	Minnesota—July
Jessie L. Stevenson	Flint, Mich.—July 1-3; 8-10
Alberta B. Wilson	Syracuse, N. Y.—July 18

In the latter part of June, Agnes Fuller visited Baltimore, Md., and Mable Grover was in Memphis, Tenn.

HAWAII NURSE LOSES LIFE

Jane Service, veteran public health nurse on the Island of Hawaii and life member, NOPHN, lost her life in the tidal wave which struck Hawaii on April 1, 1946. Coming to Hawaii in 1925 as chief public health nurse on the Island, she played a large part in establishing the public health service there. Miss Service, a graduate of Lakeside Hospital School of Nursing in Cleveland, Ohio, had a varied background of nursing service before leaving the mainland. She retired in 1944. Thelma Patten, secretary, Nurses Association County of Hawaii, writes of her: "Her old Model T Ford was known the length of the Island, and her loyalty and devotion to work and to her nurses, recognized throughout the territory. . . . Miss Service was buried in Hilo, on the Island she loved and served for two decades. Hers was a valiant spirit, and there are many who mourn her tragic death and say with deep regret their last 'Aloha.'"

WHAT MEMBERS AND FRIENDS ARE DOING

Mrs. Nan Cox Hare, Red Cross nursing consultant for the Volunteer Nurse's Aide Corps and the Recruitment and Released Nurse program, Southeastern Area Office, Atlanta, Georgia, became Red Cross nursing field representative in St. Croix, Virgin Islands, in April, a post she formerly held from 1929 to 1933. . . . *Mrs. Charlotte M. Heilman,* of Bound Brook, N. J., recently retired from her post as nursing field representative for New Jersey and from active Red Cross duty after serving continuously since 1918, both in the United States and abroad. . . . The New York State Department of Health announces the retirement of staff members *Bertice A. Rees* and *Helen A. Bigelow,* on April 1 and May 1, respectively. Both held the title of consultant public health nurse, Division of Maternity, Infancy and Child Hygiene, and had been with the Department since 1925 and 1926 respectively. . . . *Frances A. Anderson,* for ten years assistant director, has been appointed director of nurses at Woman's Hospital, Detroit, Michigan. *Mrs. Bertha B. Shopinsky,* retiring after 17 years in school and community nursing, Purchase, New York, will be succeeded by *Eleanore Lorenz.*

NEWS AND VIEWS

On National Nursing

STUDY OF CHILD HEALTH SERVICES

A nationwide study of child health services has been launched by the American Academy of Pediatrics with the cooperation of the U. S. Public Health Service and the U. S. Children's Bureau. This study of medical and health care for children is of importance to every nurse concerned with child health, whether she is serving in a hospital, public health agency, or is engaged in private duty nursing.

The study, instigated by pediatricians throughout the United States, originated in a resolution adopted by the Academy of Pediatrics in 1944 "to make available to all mothers and children in the U. S. A. all essential preventive, diagnostic and curative medical services of high quality which, used in cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens." To achieve this objective, the facts concerning the present status of child care must be known. Knowledge of these facts can obviously be obtained only through extensive research into the personnel, facilities, and services now available. No one source can provide all the needed information; much of it must necessarily be secured from those individuals directly concerned with the activities involved.

The development of the study as a joint enterprise of private and official health organizations represents a significant step toward cooperative action, a necessary step in view of the tremendous scope of the proposed program. The procedure for collecting the vast amount of data involved has been organized on a state basis with the state Academy chairman and one or more executive secretaries responsible for the administration of the study in each state. Many organizations and agencies are being called upon to participate in the study in order that a complete and accurate picture of the whole child health program may be obtained. In the majority of states the study has already received the full approval of state medical groups and state departments of health. Cooperation of the Commission on Hospital Care has been secured, and in those areas where hospital studies are being conducted, the Academy's study is being correlated as fully as possible to avoid duplication.

Three series of questionnaire schedules covering hospitals and related institutions; health services including well-child conferences, mental hygiene clinics, communicable disease control programs, school health, and public health nursing activities; and the private practice of pediatricians, general practitioners and dentists are already in process of distribution. The information sought by these schedules has been reduced to the essential minimum, and only those data not available from other sources are requested.

Nursing services for children provided by hospitals and other institutions and by health agencies, both public and private, are included in the study. The acquisition of data on such programs depends entirely on the cooperation of all nurses reached by the study. Only those individuals actively engaged in the provision of these services can furnish the specific information needed.

The study of child health services represents an attempt on the part of professionally trained medical personnel to evaluate activities in their own field as a basis for stimulating the betterment of child health care in this country. It is anticipated that whatever needs are revealed by the study, further action will be determined by national, state and local groups on the basis of the information acquired. The present program represents only the first step in the achievement of the objective. Once the facts are known they will be made available to all interested groups and community planning can then proceed on a sound factual basis.

PLACEMENT SERVICE MARKS FIRST YEAR

Completion of the first year of existence of the ANA Professional Counseling and Placement Service, Inc., was celebrated at a tea at national headquarters the afternoon of June 14. Describing the first year of the Service, Ella Best, executive secretary of the ANA, stated that through its expanding program of counseling and placement increasing direction and guidance is being given to the "greatest turnover ever known among American nurses." Nurses today, she said, are pushing on to new frontiers; they are looking to the future rather than fitting themselves to prewar employment patterns.

Special guests at the tea included six state counselors enrolled in a three-weeks course for nursing counselors offered by the Division of Nursing Education, Teachers College, Columbia University. A similar course will be given at the University of Colorado, August 12-24.

Designed to serve employers of nurses as well as employees, the Counseling and Placement Service is assisting many nurse veterans as well as nurses with civilian experience only. Postwar plans of 31,000 Army nurses, 10,000 Navy nurses, and a sampling of nurses who remained in civilian positions have been studied through a questionnaire survey, and together with personal interviews and psychological tests are believed to provide a substantial factual basis for the next year's work. Present staff at national headquarters include: Helen M. Roser, R.N., nurse consultant; Edith F. Davis, research consultant; Mrs. Bertha G. Byrne, R.N., assistant executive secretary, Chicago branch office; and newly-appointed Dr. Grace McGlinchey, personnel consultant.

From Far and Near

● First nationwide convention in five years of the American Occupational Therapy Association will be held at the Congress Hotel, Chicago, August 12-14. Recent developments in physical medicine and in the interest which the medical profession is expressing in the total field of rehabilitation make this an important meeting. Outstanding physicians, psychiatrists, and occupational therapists will present latest information on the progress and future developments in this field.

● Third birthday of the U. S. Cadet Nurse Corps, USPHS, on July 1, 1946, found more than one hundred thousand cadet nurses studying in 1,100 schools of nursing throughout the country. Included in this number are first, second, and third year students enrolled by October 15, 1945, the last of whom will graduate in 1948.

● Anna M. Fillmore is the newly-appointed assistant director of the Visiting Nurse Service of New York to succeed Elisabeth C. Phillips who becomes the director of Public Health Nursing Curricula at New York University on September 1. Miss Fillmore is a graduate of the Latter Day Saints Hospital School of Nursing, Salt Lake City, Utah, and holds a B.S. degree from Teachers College, Columbia, a certificate in public health nursing, University of California, Berkeley, and a M.P.H. degree, Harvard School of Public Health. Since 1940 she has been staff nurse, supervisor, and industrial nursing consultant, VNS of New York; prior to that she was state director of public health nursing, Utah, and assistant director, American Nurses' Association. Miss Fillmore is chairman of the NOPHN Industrial Nursing Section.

Miss Phillips, who has been staff nurse, educational assistant, assistant director, and acting director, VNS of New York, was on leave of absence in 1941-1942 when she went to England as associate director of the American Red-Cross-Harvard Field Hospital Unit, in charge of the Public Health Nursing Program. She is a graduate of the Johns Hopkins Hospital School of Nursing, Baltimore, and has her B.S. and M.A. degrees from Teachers College, Columbia University. She holds diplomas from the Henry Phipps Psychiatric Clinic, Baltimore, and Maternity Center Association, New York. In 1932-1933 she was instructor and supervisor in surgical nursing, University of Minnesota. From 1935-1937 she was supervisor and instructor in midwifery, Maternity Center Association, New York; and from 1937-1939, educational director, Westchester County (New York) Department of Health. She was an instructor at Teachers College, Columbia, 1937-1941 and lecturer, 1942-1946; also lecturer at New York University, 1945-1946. Miss Phillips is NOPHN representative on the Joint Committee on Auxiliary Nursing Service.

Harmon Retirement Plan for Nurses—Current interest in social security benefits, and pensions in particular, makes a review of existing retirement plans worth while. Much publicity has been given recently to the new National Health and Welfare Retirement Association plan for employees of health and welfare agencies (See *Phn*, NOPHN news bulletin, March 1945, and PUBLIC HEALTH NURSING, June 1945, p. 329). Another plan for individual nurses and employees of nursing groups, longer established and one with which most nurses are familiar and in which many are already participating, is the Harmon Retirement Income Annuity Plan. Sponsored by the Harmon Association for the Advancement of Nursing, Inc., a nonprofit membership corporation, the Harmon Plan is a group annuity system for registered nurses, endorsed by the four national nursing associations—ANA, NACGN, NLNE, and NOPHN. Individual participants in the plan, who may be reg-

istered nurses or non-nurses closely associated with the nursing profession, must be members of the Association. Association dues are $2.00 annually.

Monthly payments are made of $5 or any multiple of $5—$10, $15, $20, whatever the individual can afford. The amount selected can be decreased at any time or increased whenever the rate of payment has been maintained for at least twelve months. Lump sum payments in multiples of $100, within limitations, may also be made. The monthly annuity income depends on age, amount of monthly payments, lump sum payments, dates of payments, and the normal retirement date selected. Retirement may be at the normal ages of 60 or 65, or can be anytime between ages 50-70. The later the date, the greater the income and vice versa. Cash surrender value is the actual amount of total payments, and this is available at any time, before or after retirement date, provided annuity income payments have not commenced. Upon death, the total amount of deposits will be paid to the beneficiary, or in case some income payments have already been made, the difference between amount of income payments made and the total amount paid in will be paid to the beneficiary.

The annuity income payments are made and guaranteed for life by the Metropolitan Life Insurance Company, but the plan is administered by the Association through trustees who serve without pay and who safeguard members' interests by constant supervision.

There is also available a plan whereby employers can contribute to the retirement fund of the employees, with the amount deposited by each flexible, as in the case of the individual plan. The other terms for the employer-employee plan are also similar to those of the individual plan.

In comparison with other plans, some of the features of the Harmon Retirement Plan are particularly advantageous—no loss or forfeiture of principal under any circumstances, privilege of withdrawing total payments in cash at any time before annuity income payments begin, et cetera. The rates of return on deposits compare favorably with those obtained on an individual basis from the usual insurance company.

The Harmon Association also sponsors group accident and sickness insurance for nurses and group hospitalization. For further information write: Harmon Association for the Advancement of Nursing, Inc., 140 Nassau Street, New York 7, N. Y. Representatives of the Association will occupy Booth D at the Convention in September.

Average Daily Attendance Resolution—Changing the California law which apportions funds to school districts on an average daily attendance basis "to the end that children may be encouraged to secure adequate treatment of and protection from illness, and may stay out of school for such treatment without loss to the school district of official attendance credit and financial support" is the objective of the so-called ADA Resolution approved by many individuals and organizations concerned with the health of the California school child. The resolution is of interest to school nurses in other states where similar legal provisions are in effect. Average daily attendance, or "ADA," for years the basis of a major state appropriation for public schools in California has, according to local press comment, resulted in overemphasis of the importance of attendance by teachers and administrators. As a result, "serious-minded children and parents have arrived at a state of mind concerning school attendance which has caused children to be sent to school and has caused the children themselves to strive to go to school when the long-term best interests of their educations and their lives would have been served better by a day or two of absence, for rest and care. It is bad school policy to force a sick or ailing child to school simply for the purpose of keeping a perfect attendance record and of making one more unit for state subsidy. An ailing child in school can add little to his learning, his attending can detract much from his health, and the ailment may spread to other children.

Epidemic Situation in Europe—The epidemic situation in Europe is more favorable than was expected a year or so ago, except for typhoid and diphtheria, states the UNRRA Health Division in *Epidemiological Information Bulletin,* April 30, 1946. This condition prevails despite the fact that a state of progressive undernourishment exists in a considerable part of Europe. The incidence of both typhoid fever and diphtheria, however, is many times higher than it should be at this time of the year.

Modern methods of control have held typhus down to a far lower level than was anticipated. Except in Roumania, only sporadic cases of relapsing fever have appeared. Cases of smallpox have been limited to an epidemic of the mild type in Italy and a few cases elsewhere. Plague has not gained a permanent foothold on the continent, and cholera has not touched the continent at all. The continued absence of influenza of severe type is the most important aspect of the situation. "A wave of very mild influenza was in evidence in several countries from December to January. It appears to have been influenza B, and the very moderate mortality which ensued was of the common old-age type. The mystery of the 1918-19 pandemic has not and perhaps never will be solved. Had it arisen once more, little could have been done to arrest it."

Less prevalent also than during the early years of the war was cerebrospinal meningitis. There have been a few epidemics of poliomyelitis, but they occurred less during the latter years of the war. Epidemic jaundice seems to be receding and dysentery epidemics have decreased much more rapidly than in the case of typhoid fever.

During the war, especially from 1942 on, there was a marked increase of most epidemic diseases

on the continent, the most spectacular being that of diphtheria. Dysentery and typhoid fever were partially warded off; an onslaught of typhus was fully met. The potential menace of such diseases as cerebrospinal meningitis, poliomyelitis, and epidemic jaundice did not materialize. The situation, on the whole better than expected, is attributed to the work accomplished during the period between the two wars and to the progress of preventive methods developed during the war. Among the latter elements, DDT probably ranks first, certainly as far as the prevention of louse-borne diseases is concerned. The development of various vaccines is also of great importance. Another factor is the low level of epidemic diseases reached between the two wars.

The satisfactory state of epidemic diseases, according to the report, does not extend to infectious diseases with a social slant. Tuberculosis mortality and morbidity has increased greatly as has the incidence of venereal disease.

Streptomycin Restricted to Program of Clinical Investigation—A present very limited supply of streptomycin is being restricted to a program of clinical investigation of nine diseases specified by the National Research Council Committee on Chemotherapeutics and Other Agents, Chester S. Keefer, M.D., chairman, reports in the *Journal of the AMA*, May 4. Streptomycin is relatively new to the medical profession, and much remains to be learned concerning limitations of its usefulness, methods of administration, dosage, toxicity, et cetera. Most of the information thus far has been obtained from military and civilian hospitals as a result of clinical investigations carried out under arrangements between producers of streptomycin and individual clinical investigators. A fraction of the streptomycin is now being allocated to Dr. Keefer's committee for continuation and amplification of the studies. Distribution will be made to those hospital physicians most competent to obtain the vitally needed information. In addition to the group of accredited investigators, individual physicians will be included in the research program when they have patients with diseases being studied by the committee. These diseases are: (1) gram negative bacillary infections of the genito-urinary tract resistant to the sulfonamides (2) gram negative bacillary infections with bacteremia (3) hemophilus influenzae infections, including meningitis, pneumonia, middle ear disease, and laryngotracheitis (4) Friedlander's bacillus pneumonia (5) typhoid (6) salmonella infections (paratyphoid) (7) acute brucellosis with bacteremia (8) tularemia and (9) bacterial endocarditis due to gram negative bacilli.

Diseases not now being investigated by the committee are: chronic idiopathic ulcerative colitis, lupus erythematosis acutus disseminatus, leukemia, cancer, fever of unknown cause, rheumatic fever, and rheumatoid arthritis.

All streptomycin now being produced must be reported to the Civilian Production Administration for allocation by it to the Army, Navy, USPHS, Veterans Administration, and the National Research Council. No other agency may purchase it; no physician is charged for it; and no patient receiving it must pay for it. The present research program is being conducted "by the concerted efforts of the government, streptomycin producers, the National Research Council, and civilian medical scientists of the highest standing with the sole purpose of obtaining the necessary information concerning streptomycin in the shortest possible time."

Nation Neglects Children with Hearing Difficulties—Findings of a recent review by the U. S. Children's Bureau of various state and federal programs to assist children with hearing difficulties indicate that relatively little is being done to enable the estimated one million children with impaired hearing in this country to overcome the handicap. Seven states have effective laws requiring hearing tests for school children, and a few others operate programs for hard-of-hearing children. No state, however, has complete testing of all school children, and such testing is the first and essential step, according to the Children's Bureau. The second step is to provide good medical care and other help for all children found to have a hearing impairment, "but nowhere in the country is such follow-up care being provided for all children." As a result, thousands of children are left to struggle along as best they can, and many are made to feel inferior in the home and at school because they are not as quick as others. Some eventually drop out of school without the reason for their "dullness" being recognized. "What is needed," Dr. Martha M. Eliot, associate chief of the Children's Bureau, states, 'is a nationwide program that would bring preventive diagnostic, and remedial care within reach of all these children. Care in time would prevent damage to the hearing in many instances. In cases where some damage has already been done, much can often be done to check further loss. Even where the handicap is a permanent one, many are able to take their places in the work-a-day world, if they are taught lip-reading or if they are fitted with a hearing aid."

See also PUBLIC HEALTH NURSING, April 1946, page 208, for a method of testing the hearing of very young children; and February 1946, page 85, for recommendations relative to problems of the hard-of-hearing school child

Diabetes Mellitus, Prevalence and Outlook—Estimates indicate the prevalence in 1940 of at least 500,000 cases of diabetes in the United States and an anticipated increase at a greater rate than the population in the next few decades. The increasing import-

ance of this disease and the outlook for the future, based upon the National Health Survey of the U. S. Public Health Service, 1935-1936, and the Massachusetts survey by Bigelow and Lombard in 1929-1931, are reported in the *American Journal of Public Health*, January 1946, by Mortimer Spiegelman and Herbert H. Marks.

At least 50,000 persons, according to the report, became diabetic during 1940—about two fifths were males and three fifths, females. Computations of the chances among men and women of different age groups indicate that up to age 50, almost twice as many females as males are apt to become diabetic—over 4 percent of the females and more than 2 percent of the males. The proneness of females to contract the disease on approach of the menopause is indicative of the endocrine changes characteristic of that period of life. The chances of eventually becoming diabetic are greater than the chances of eventual death from the disease, since many diabetics die from other causes.

Diabetes is primarily a disease of later life. The average age of living male diabetics is 56 years, and of females, 57 years. Of the known diabetics in 1940, not quite half were under 55 at onset of the disease; somewhat more than one quarter became diabetic between ages 55 and 64; and one quarter were at ages 65 and over when they developed it.

During the next few decades the number of diabetics in the United States will increase at a much greater rate. The more rapid increase of the diabetic population than of the total population arises from two factors: (1) the ever increasing proportion of persons at the older ages and (2) the more rapid increase in the number of females than of males at these ages. From 1940 to 1950, an increase of 18 percent may be expected in the number of diabetics, while the total population is expected to grow only by 9 percent.

Although research is under way on the prevention of diabetes, the prospects for practical results, the authors state, do not yet warrant the assumption of a favorable effect on future diabetes prevalence.

Civilians Gain from Army Psychiatric Experience—Tremendous benefits to civilians can accrue from application of psychiatric advances made by the Army during the war years, declared Brigadier General William C. Menninger, director, Neuropsychiatry Consultants Division, Surgeon General's Office, in a recent statement. There must, however, be a wider dissemination of these gains among the practicing physicians, and more workers must be attracted to the field of psychiatry. The size of the problem is indicated by the fact that 314,500 men had been discharged by July 1, 1945, for neuropsychiatric causes—43 percent of all medical discharges; 130,000 more for personality defects. Out of almost 5 million men rejected for all causes, 39 percent were rejected for some personality disorder.

A majority of these men will be able to make a normal adjustment in civilian life, states General Menninger. Satisfaction in work and play, security and understanding on the part of family, employer, and friends provide the best medicine for these veterans.

The two major innovations in Army treatment of these cases have been psychotherapy under sedation and group psychotherapy. In psychotherapy under sedation, sometimes referred to as narcosynthesis, the patient is given an intravenous dose of a sedative drug which brings him to a state of semi-stupor in which he is encouraged to talk and relive the emotional experiences which helped bring about his condition. With the help of a skilled psychotherapist, the patient is given "free and adequate drainage" for his emotional tension, an important factor in recovery. Good results are also obtained when a man is hypnotized and an "emotional catharsis" is produced similar to the results obtained when drugs are used.

The other significant development in psychiatric treatment during the war, group psychotherapy, consists of bringing together in a group 15 to 25 patients with similar problems for an hour a day for 10 to 30 discussions. Under the guidance of the skilled therapist, the patients compare experiences and as a result of the insight gained in their cases good results are obtained in a fair percentage of the group.

The Army experience provides convincing proof, General Menninger reports, that the modern physician must become acquainted with psychological medicine and the dynamics of personality adjustment as well as with the physical aspects of medical practice. Surveys in wards treating patients suffering from heart disease and gastrointestinal trouble have showed that in as high as 41 percent of cases there was no organic trouble. The emotional maladjustment of patients often leads to the malfunctioning of certain organs of the body.

The psychiatrist is concerned with the treatment of cases suffering from functional disorders due to emotional tension, but if doctors generally had a better understanding of the principles involved in this work, great benefits would be derived by civilians in industry and all walks of life. The role of emotional factors in such cases represents one of the most promising areas of research with perhaps the largest reward in results of any group of problems in medicine. A major step forward will be the joint approach of the internist and the psychiatrist.

American Book Center Program—The American Book Center for War Devastated Libraries, Inc., has launched a campaign to collect books and periodicals to restock war devastated libraries throughout the world. In soliciting contributions, the Center stresses the need for "publications issued during the past decade, scholarly books which are important contributions to their fields, periodicals (even incomplete volumes) of significance, fiction and nonfiction of

distinction." All subjects — history, the social sciences, music, fine arts, literature, and especially the sciences and technologies—are wanted. Shipments should be sent *prepaid* via the cheapest means of transportation to The American Book Center, care of The Library of Congress, Washington 25, D.C. When possible, periodicals should be tied together by volume. It will be helpful if missing issues are noted on incomplete volumes.

APHA Report, 1945—In his annual report to the Governing Council of the American Public Health Association, Dr. Abel Wolman, chairman of the Executive Board, *American Journal of Public Health*, May 1946, emphasized two challenges which confronted the Association in 1945. One had to do with the accrediting of schools of public health and the other involved expansion of the Association's employment service to include vocational guidance to returning veterans and to act as liaison between employers and professional personnel in the rapidly expanding field of public health.

The first project advanced to such an extent that the Committee on Professional Education was able to announce early in 1946 the accreditation of several institutions to give the degree of Master of Public Health. The Committee is now engaged in formulating criteria for the degree of Doctor of Public Health. According to the report, the Committee is resolved that its accreditation "shall be an incentive to experimentation and diversity rather than an influence for forcing education for the public health professions into a uniform mold. It will suggest only very broad principles both of organization and of curriculum, but will insist on a set of minimum criteria representing the best consensus of opinion of both teachers and practitioners."

When the war ended the Association saw an opportunity for expanded usefulness to returning veterans through its Employment Service, if it could be strengthened by full-time trained personnel in the Central Office. The U. S. Public Health Service, meanwhile, faced with hundreds of inquiries from veterans, recognized the advantages of a single agency handling such matters and was receptive to a cooperative arrangement with the Association. As a result a Vocational Counseling and Guidance Service has been established in the Association for public health workers and employers, both veteran and nonveteran. Through federal funds, a consultant has been added to the Central Office staff to supply information and guidance. There is, as a result, continuous and close cooperation with the Public Health Service through the Surgeon General's Committee on Postwar Training and Recruitment. Arrangements have been worked out whereby all public health nursing inquiries are referred to NOPHN.

From the official declaration of the Association, prepared by the Subcommittee on Medical Care of the Committee on Administrative Practice in October 1944, affirming the Association's belief that a program of medical care designed to reach all the people is essential and its conviction that an overall program can be realized within 10 years, have stemmed two important developments. One implements the work of the Subcommittee—the latter having received a grant from the Rockefeller Foundation to establish an office in Washington with a full-time technical staff to review proposed federal and state health legislation, and recommend to the Association the stand it should take with regard to such legislation in the light of its declared principles. The second development, which will aid in the achievement of the Association's objectives through focus on one of them—"the extension of knowledge," is the approval by the Executive Board of a plan for the provision of annual awards, through the Albert and Mary Lasker Foundation, to shorten the time between a scientific discovery in the field of medicine or public health and its general use in practice, particularly in the field of prevention. First priority will be given to research with relation to the diseases which are the leading causes of death. There is also opportunity to recognize administrative achievement in the prevention and treatment of these diseases. The need for increased information among the public health professions about the causes, treatment, effective care, and prevention of these most serious diseases is obvious.

Also highlighted in the Chairman's report were section and committee activities, many of which concern public health nursing directly or indirectly. For example:

The School Health Section has organized a Rural School Health Committee, and committees to study school health legislation and pre-service and in-service training of school health personnel.

The Public Health Education Section is reported to have developed a wholly new technique of committee work. In an experiment designed to increase member participation in Association and Section activities, and at the same time to develop "grass roots" interest, its Section work has been carried on through six regional committees, each studying the resources and problems of the area in which the members live. The committees are composed of all members of the Section in a given area. At the Annual Meeting of the Association in 1946, the Section program will be based on this regional organization, which will give an opportunity to exchange diverse experiences and weld them into common objectives, though variously manifested.

The Merit System Unit, conducted also under the Committee on Professional Education and now ending its fifth year of work, has a stock pile of examination items in 8 fields of public health, one of which is public health nursing. The latter have been provided most numerously in 1945—91 examinations in 21 states, states Dr. Wolman.

Reprints of the report are available free upon request from the American Public Health Association, 1790 Broadway, New York 19, N. Y.

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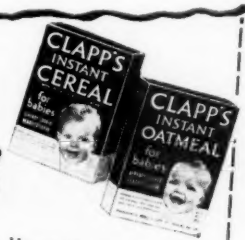

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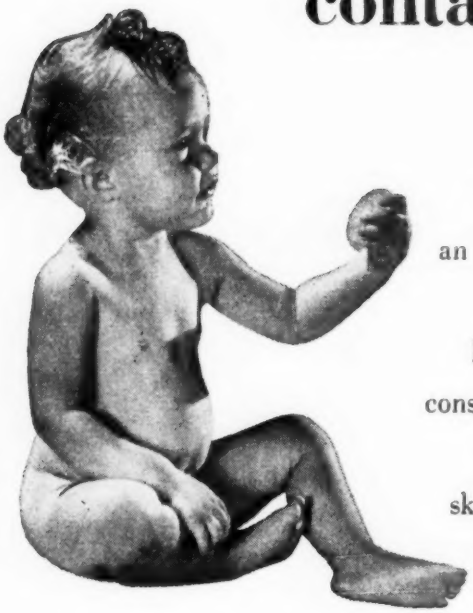

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In Low Caloric Diets Breakfast Is Doubly Important

In order to preserve the health of the patient, the low caloric diet must be nutritionally adequate in every respect, except in its caloric content. In order to avoid excessive hunger which might render such a diet more difficult for the patient, medical and nutritional authorities recommend that one third of the daily food allowance be assigned to each meal, distributing the total equally over the day.

Hence in the customary 1,200-calorie diet breakfast equals the other two meals not only in calories, but in protein, carbohydrate, fat, and auxiliary nutrients as well. In this manner no excessive digestive burden is placed upon the organism called upon to metabolize its stored fat.

Cereals, whether to be cooked or ready to eat, fit well into the low caloric diet. The large variety of form and taste available makes for appetite appeal and permits daily variation if desired. The dish consisting of 1 oz. of cereal, 4 oz. of skim milk, and 1 scant teaspoonful of sugar provides but 158 calories, yet supplies biologically adequate protein, B complex and other vitamins, and essential minerals. Cereals, because of their advantageous composition, may well be included not only in the formulation of the breakfast, but the other two meals as well. The nutritional contribution made by 1 oz. of cereal (whole grain, enriched, or restored to whole-grain values of thiamine, niacin, and iron), 4 oz. of skim milk, and 1 scant teaspoonful of sugar is indicated by this table of composite averages:

Calories	158
Protein	6.9 Gm.
Fat	0.6 Gm.
Carbohydrate	32 Gm.
Calcium	158 mg.
Phosphorus	207 mg.
Iron	1.8 mg.
Thiamine	0.17 mg.
Riboflavin	0.27 mg.
Niacin	1.4 mg.

The presence of this seal indicates that all nutritional statements in this advertisement have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

CEREAL INSTITUTE, INC.
135 SOUTH LA SALLE STREET • CHICAGO 3

POSITIONS AVAILABLE

PUBLIC HEALTH NURSING lists "Positions Open" each month. Up to 50 words this service is *free to member agencies*, with a charge of $2 for an additional 50 words or less. To other organizations the charge is $2 for the first 50 words or less, and $2 for an additional 50 words or less. Please send payment with the ad.

WANTED—Nursing Arts Instructor in 100 bed hospital. Salary $180 per month plus maintenance. Apply: Director of Nursing, East Liverpool, Ohio.

WANTED—Director, Greenfield Visiting Nurse Association. Generalized program. Public Health Certificate. Salary $175-190. Staff of 3 nurses. Student affiliation with local hospital. Organization owns 3 cars. Month's vacation, 2 weeks' sick leave. Attractive New England town, population 15,000. Apply: Mrs. James R. Turner, 27 Norwood Street, Greenfield, Massachusetts.

WANTED—Public Health Nurse for staff position in official generalized program of Montgomery County, Md. A large suburban section of Washington, D. C., lies in this beautiful county, thus offering opportunity for both suburban and rural experience. Salary, $1900-2200, based upon education and experience in public health nursing. Make application to Montgomery County Health Department, Rockville, Md.

WANTED—Resort areas of Michigan need qualified public health nurses to help develop expanding programs of local health departments. Personnel policies are written to offer staff members opportunities to enjoy water and woodland sports and outdoor life the year around. Positions are open immediately for 10 staff nurses at a salary range of $2100 to $2220; 2 senior nurses at $2400, and 2 supervising nurses at $2700 to $3000. Write for a personnel form to the Director, Northern Peninsula Office, Michigan Department of Health, Escanaba, Michigan.

WANTED—PUBLIC HEALTH NURSES ARE NEEDED IN GEORGIA: The State and County Departments of Public Health in Georgia invite qualified public health nurses to apply for permanent positions in Georgia. Staff nurses must have a minimum of six months post graduate public health nursing education in addition to acceptable basic training. Salaries range from $1860 to $2040 in addition to a liberal travel allowance. Supervisory nurses must have at least two years' experience in public health nursing as well as one academic year of post-graduate training in public health nursing. Salaries range from $2100 to $2280 in addition to travel allowances. Scholarships are available for graduate nurses who are interested in receiving public health nursing training. Write Personnel Administrator, State Health Departmet, State Office Building, Atlanta 3, Georgia, for application forms and full details.

What every Nurse should know

...about Carnation

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- ★ It freezes.
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- ★ It can be served undiluted (*twice as rich as whole milk*) with cereals, fruits, coffee, and tea.
- ★ It's homogenized and sterilized for easier digestion and safety, and fortified with vitamin D—ideal for special diets and baby formulas.
- ★ It makes wonderfully smooth and rich cream sauces and soups.
- ★ It's easily acidified with lemon juice or vinegar, for use in sour milk or sour cream recipes.

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